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ABSTRACT

Using a developmental approach to establish a rational model for the assignment of tasks and roles to various levels of mental health manpower, 36 participants attended four 2-day seminars which were concerned with needs of clients, activities to meet the needs of clients, needs of agencies and institutions, and legal, institutional, and professional constraints. Mental health agencies have traditionally clustered tasks and activities according to professional specialities, agencies, or specific tasks, none of which is particularly responsive to client needs. It was recommended that the highest priority of rationales for clustering jobs and activities be target groups of persons. This is the notion of the generalist whose primary focus is on meeting the needs of the client. In addition, 15 functional roles were identified, and four levels of workers (entry, apprentice, journeyman, and master) were determined. Role clusters are charted, and implications of the generalist notion are included for clients, families, communities, workers, agencies, professions, personnel systems, educational programs, and finances. (SB)

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ROLES AND FUNCTIONS FOR MENTAL HEALTH WORKERS

A Report of a Symposium

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ROLES AND FUNCTIONS FOR DIFFERENT LEVELS OF MENTAL HEALTH WORKERS

A REPORT OF A SYMPOSIUM

ON

MANPOWER UTILIZATION FOR MENTAL HEALTH

December, 1969

COMMUNITY COLLEGE MENTAL HEALTH WORKER PROJECT
Southern Regional Education Board
130 Sixth Street, N.W.
Atlanta, Georgia

The Project PROMOTION OF COMMUNITY COLLEGE MENTAL HEALTH WORKERS is supported by National Institute of Mental Health Grant Number MH10879-03. Its purpose is to promote the development of community college workers as a significant manpower resource by determining job duties of workers, facilitating the establishment of job descriptions and funded positions in agencies, facilitating the development of community college training programs and curricula in mental health, disseminating information and reporting and analyzing experiences in the various states.

During the course of the symposium, Dr. Steven Cornett of the Office of Field Coordination, Department of HEW, conceived and sketched a number of cartoons appropriate to the subject being discussed. We appreciate his permission to reproduce a few of them here.

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ROLES AND FUNCTIONS FOR DIFFERENT LEVELS OF MENTAL HEALTH WORKERS

INTRODUCTION

Many mental health agencies have been concerned about ways to use new levels of mental health workers, yet no overall rationales have been developed for their use, either in regard to clients, to the workers, or to the existing professions.

This publication is a report of the rationale and recommendations of a symposium to determine appropriate roles and activities for various levels of mental health manpower. It is not offered as a template that should be emulated exactly as it appears here, but rather as a guideline which may be helpful to agencies, professionals and trainers in making the best use of new mental health workers.

In an analogy, it is as if the prime mode of long distance travel had been only the railroads which were carefully organized with maps, timetables, and rate schedules. But now people want to travel by highway--some by auto, some by bus, and some perhaps by motorbike. What this document offers is a basic highway map of the same country that formerly had only railroad maps. Some of the alternate routes are shown, and some considerations for choosing one over the other. However, it does not specify routes, schedules, or destinations. It is the responsibility of each agency to make its own decisions about where it wants to go, what routes it wishes to use, and in what kinds of vehicles it wishes to travel. Some agencies, like some people, will choose to stay with the railroad, and some will want to use still other ways, such as sailing ships or airplanes.

No part of this publication intends to be a directive to any agency; rather it stresses the flexibility of the scheme it outlines. Four levels

were chosen because these seem to be the major areas of concern today. Some agencies may wish to consider only three or only two levels of workers; others might want to subdivide these four levels. Surely personnel men will want to add several steps to each level. In a similar manner the roles can be further subdivided or collapsed or combined in almost any way that is logistically feasible. This scheme can be modified in many ways.

This document very definitely does not spell out a finite number of jobs, nor are any of these guidelines appropriate to use as specific job or position descriptions. Those must be written by each individual agency. In addition, it must be stressed that this was a "think tank" approach, involving several persons who are experimenting with new levels of manpower, but these guidelines need to be tested in real agency situations.

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Associate Director for Mental
Health Training and Research

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PART I

BACKGROUND AND RATIONALE FOR A SYMPOSIUM

THE PROBLEM

In its efforts to promote training of manpower to meet the mental health needs of the South, the Mental Health Unit of the Southern Regional Education Board has been greatly concerned with the development of new levels of manpower.

It has been apparent for the past decade (particularly since Dr. George Albee's *Mental Health Manpower Trends*, a monograph of the Joint Commission on Mental Health and Illness, 1959) that we cannot hope to meet mental health manpower needs by using only traditional professionals in traditional ways. This is especially true of the public mental health services.

Throughout the nation there have been many efforts to develop new levels of workers for mental health. Some have grown from the New Careers movement and have stressed providing employment for the "indigenous non-professional," others have trained mature housewives for mental health work, and some have considered various aide, assistant, or technician-level workers who might be trained in junior colleges or four-year colleges.

In most of these efforts the focus has been on the training program rather than on defining the roles in which these persons might function. Because of this imbalance of emphasis, nearly all of these programs met with considerable frustration and resistance when the new workers came up against established agencies and professions. There were sometimes no jobs available, or jobs at only the most menial levels, or jobs with no direction or challenge. The established professions have often considered these workers

HOW DO YOU WRITE JOB DESCRIPTIONS
FOR JOBS THAT DON'T EXIST?

to be cut-rate "non-professionals" or "sub-professionals" who were there as a temporary expedience, to be replaced as soon as full professionals became available.

In almost no case has there been a rational model for appropriate roles and functions of these new workers in relation to the existing agencies and professions that are committed to serving the mental health needs of society. A rational model is badly needed for administrators of agencies in which these people will work and for training program directors who will prepare them for work. The model should encompass a wide variety of mental health programs and should look at the roles of all levels of workers, including professionals as well as aides or entry-level workers.

Such a rational model will have great implications for the use of new levels of manpower, the development of career ladders in mental health, and the training of all levels of workers. It is important to keep these implications in mind as we go about the business of creating new kinds of workers in a "people working" field like mental health. The state of the art in job analysis is still quite primitive when we talk about work activity that deals primarily with people rather than products. The state of the art in job analysis is also primitive in the area of the mental health professions.

The SREB Mental Health Unit's interest in this dilemma grew out of two projects concerned with the development of middle-level workers. The primary one is a project supported by the National Institute of Mental Health to assist in the development and use of mental health technicians who might be trained in the community colleges of the South with an Associate of Arts degree. The other is a project supported by the Social and Rehabilitation Service concerned with strengthening the training and use of baccalaureate level social welfare workers, many of whom work in mental health programs. While the symposium that produced this document was conducted under the first

of these projects, the participants were urged to keep in mind the broad view of mental health services and of mental health manpower.

THE APPROACH

As we explored the processes by which different levels of manpower are developed in any technical or professional field, we learned that there are essentially two approaches: the *job factoring* approach and the *developmental* approach.

Most commonly used is the job factoring approach in which the existing professional jobs are broken down into their component tasks and activities, and the pieces assigned to various levels of workers. The pieces assigned to a new worker are likely to be the more boresome, choresome, and least challenging aspects of the work, and he is seen as an aide or assistant to an existing profession. He is perceived as a "non-professional" or "sub-professional." Such jobs are quickly developed and are acceptable to the established professionals, but they are dead-end and frustrating to the job holder because they allow him no opportunity to use his own initiative, creativity, or judgement. New dimensions to traditional practices are seldom conceived.

The needs of clients are almost always broader than the coverage by the professions, and professionals in agency practice tend to function in traditional and fixed ways that may leave the client's needs unmet in certain important areas. For example, most professionals see clients in an office setting with daytime working schedules, by appointment only and in a one-to-one relationship. In agencies or institutions there may also be additional administrative restrictions such as fee schedules, age restrictions, or residence requirements that make it difficult or impossible for clients to have

CHILD PSYCHOLOGIST

SOME OF THE TRAINING OF GENERALISTS HAS BEEN LOOKED UPON AS MERELY TRAINING A "LITTLE PSYCHOLOGIST"--OR "LITTLE SOCIAL WORKERS"

all of their needs met. One inherent fault in the job factoring approach is that it is likely to repeat these same restrictive models without re-evaluating gaps in meeting the needs of clients.

The developmental approach is a substantially different procedure which was strongly recommended to us by several employment research experts, including Dr. Sidney Fine of the W. E. Upjohn Institute for Employment Research.

In the developmental approach the starting point is the needs and problems of clients, their families and communities. After these needs have been rather graphically identified and described, the procedure moves to determining what tasks and activities should be carried out to meet the needs, regardless of who now carries them out, or whether they are being carried out at all. Then various criteria are applied to decide on logical groupings of activities for assignment to single jobs and to various levels of workers.

The developmental approach is more difficult and more controversial than job factoring, but it may produce jobs that are more responsive to client needs, that are more challenging to job holders, and that allow the professionals to extend their knowledge and competence as widely as possible without becoming hung up on traditional role models. We chose the developmental approach for the field of mental health.

There are several major professions in the mental health field. Among these are psychiatry, psychology, social work, nursing, and vocational counseling. Each of these has a few areas of unique specialized competencies, but each also shares a great bulk of knowledge and skills with the other professions. We saw no advantage to job factoring each of these professions and then trying to decide jurisdictional boundaries when there appear to be more overlapping functions than unique and specific functions.

In addition, the field of mental health is in considerable transformation. New professional modalities are coming into being. For example, in community mental health centers professionals are providing consultation, education, and aftercare, none of which is cast in traditional professional patterns.

THE PLAN

The plan we set was to hold a symposium of four two-day seminars with groups of knowledgeable people to help us establish, through the developmental approach, a rational model for the assignment of tasks and roles to various levels of mental health manpower in a wide variety of agencies and settings. The goal was to produce a guideline document that would offer somewhat hypothetical proposals for agency administrators to use in writing job descriptions and in deciding how to use new manpower in their agencies. We recognized that this approach was not based in experimental trial, even though we tried to involve among our experts several people who have had experience with various levels of new mental health workers. However, it was felt that such a document would provide a rational model for job formulation which agency administrators could adapt to their own agency's goals and functions for actual tests in operation.

Our chief consultant in this process was Dr. Robert Teare, Management Department, University of Georgia. Dr. Teare is an industrial psychologist with considerable experience and research in the area of job analysis, especially in the health and rehabilitation fields. He worked very closely with us at every step of the process.

The general purpose of each seminar was planned as follows:

Seminar 1 - To identify in graphic terms the problems and needs of clients or their families and communities that are included in the purview of mental health.

Seminar 2 - To describe the tasks and activities that are required to meet the needs identified in Seminar 1.

Seminar 3 - To identify the job inputs that derive from the institutions' and agencies' needs rather than from the needs of clients, and to identify the legal, professional, and institutional constraints on job formulation.

Seminar 4 - To pull together all of the material from the first three seminars to formulate logical clusters of activities and functions that might be developed into jobs and to develop a rationale for assigning them to various levels of workers.

THE FACULTY AND PARTICIPANTS

The first action of the symposium was to select the participants. We chose a faculty of five persons to be the brain-storming core of the symposium, to attend all four seminars, and to provide major continuity to the process. They were chosen primarily because they were thoughtful and articulate persons, knowledgeable about the field of mental health but generally not in and of it to such an extent that they were committed to any particular institutional or professional pattern of service.

They were:

1. A psychologist who is currently in the Office of Field Operations of the Department of Health, Education and Welfare, and who formerly worked in rehabilitation of the mentally ill and with the Appalachia Program
2. An educator who now is assistant director of an institute of higher education at a state university, and who was formerly with the junior college division of the state's education agency
3. A sociologist presently heading a research program to study social change, who has had a long-standing interest in mental health, and

who was formerly director of a state comprehensive mental health planning office

4. A psychologist who is presently directing a state mental retardation agency and who formerly headed a university training program for mental retardation administrators
5. A labor economist who has worked in personnel and training operations of a state department of mental health

The other participants for individual seminars were selected for their personal knowledge and experience in the area under concern in each session. For the first seminar, they were persons closely involved with clients, patients, families, and communities in such a way that they saw the clients' needs. For the second seminar, they were people closely involved in actually delivering mental health services to people, and for the third and fourth seminars, they were people concerned with program and personnel administration. Several of the participants were involved in programs to prepare and use new levels of mental health workers.

All seminars were held in Atlanta at three-week intervals from the end of January through the middle of April, 1969.

P A R T II

ACTIVITIES OF THE SYMPOSIUM

SEMINAR 1 - NEEDS OF CLIENTS

Using the developmental approach described in Part I, Seminar 1 began with the identification and description of needs of clients, their families, and the communities included in the purview of mental health.

The purview of mental health was defined to be "programs and activities that are clearly concerned with problems of mental illness or emotional disturbance--programs of mental hospitals, psychiatric clinics, community mental health centers, guidance clinics, psychiatric units in general hospitals--and also programs concerned with problems of mental retardation, programs for people with learning disabilities or minimal brain dysfunction, and programs for alcoholism."

Included were programs of social, educational, and vocational rehabilitation and restoration, as well as diagnosis and treatment of these groups. Also included were programs concerned with prevention of emotional maladjustment and programs concerned with promotion of higher levels of positive mental health among the population at large, or among specific target groups of people.

The participants of Seminar 1 were urged to range even farther afield since mental health workers are found in programs of courts, prisons, schools, children's agencies, family counseling services, etc., but we wanted to be sure that the core areas listed above were included as of highest priority.

Considerable emphasis was placed on identifying the *unmet* needs of individuals, families, and communities. Obviously not every conceivable need of all possible persons and situations was identified, although a very extensive catalog of needs was developed. Many of the needs listed were social,

economic or environmental; however, an equal number were personal, intrapersonal, and interpersonal, so that all aspects were represented.

Some of the specific obstacles to meeting the presently unmet needs of patients were listed. Among these were:

1. Rigid laws, rules, regulations and policies - Named here were rigid commitment laws, punitive welfare laws, policies regarding unwed mothers in schools, restrictions in the Aid to Families with Dependent Childred (AFDC) program, laws requiring transportation of patients by sheriffs, regulations regarding visiting hours, and requirements that patients have no visitors for two weeks.

Rigid administration and practices include the inflexible routines of general hospitals and state mental hospitals (i.e., baths only on Tuesday and Friday, no personal belongings allowed, meals at 6:00 a.m., 10:30 a.m., and 4:00 p.m.). Patients are dehumanized and made totally dependent through such inflexible rules and regulations.

2. Shortage of resources, especially lack of facilities and programs close to the people in the communities - Lack of funds and staff for programs was also named.

3. Professionalism - Named here were professional jurisdictional battles; compulsive professional practices (i.e., full-scale social histories on all patients, full batteries of psychological tests whether needed or not, insistence on full-scale staff diagnostic conferences, traditional intake procedures); professional detachment (lack of sincerity or interest); lack of commitment; disdain for certain kinds of patients and work (i.e., the aged, the alcoholic, the chronic psychotic); disdain for sub-professionals, unrealistic weight to irrelevant academic qualifications and certification; focus on the services they render (their "thing") rather than on the client's needs.

4. Lack of humanity - Time and time again mention was made of the lack of human concern and compassion in administrators, professionals, and all levels of staff. They become harsh, punitive, callous, superficial and disdainful with the disturbed people they are supposed to be serving. Too many "burn out" after a time and become more responsive to the "system" than to the basic objectives of the system--the people it serves. Fingerprinting, locking wards, and calling all patients by their first name were a few examples of acts of staff that strip patients of their dignity and humanity.

5. The stigma attached to mental problems - This was named as a problem for the public at large. It is perpetuated by newspapers, magazines, television, school teachers, clergymen, policemen, and even mental health professionals themselves. Many psychiatrists don't want to work with retarded or with chronic psychotics; doctors don't want to work with "crocks." Because of the stigma attached to mental illness, laymen are uncomfortable and ill-at-ease when working with or in the presence of a person who is not entirely "normal" or rational.

6. Acts of God - A number of people have problems that have left them with situations that cannot be entirely resolved, but must be cared for in some fashion on a continuing basis--the brain-damaged, the aged, the neurologically handicapped, the severely retarded, the autistic child, the orphaned child. Sometimes, too, there are situations in the environment of the individual that simply cannot be changed, such as geographic isolation.

7. Special problems of the deprived - Ignorance, poverty, lack of social and adaptive skills, fear and distrust of officialdom, and illiteracy.

SEMINAR 2 - ACTIVITIES TO MEET NEED OF CLIENTS

Seminar 2 participants attempted to describe specific tasks and activities required to satisfy the needs identified in Seminar 1. The list of "Needs"

from Seminar 1 and the list of "Activities to Meet Needs" have been combined and are included in the Appendix.

In the course of Seminar 2 it became clear that the same task or activity might be carried out for several different purposes; thus even a very simple and specific activity such as sweeping the floor might be used by different persons for different purposes:

1. To clean the floor
2. To teach someone else to clean the floor
3. To provide a role model of a housekeeper
4. To establish a therapeutic relationship with a client

Thus the group came to speak of "roles" as clusters of several alternative activities carried out for a common purpose or objective. Each role might be played by a worker at a very simple level or at a very complex level. The participants felt that the possible alternative activities that might be grouped for any particular role were fairly well understood by mental health professionals. Thus "roles" seemed to be a much more meaningful way of describing mental health worker functions than did the traditional industrial model of tasks and activities.

Among the roles that seemed to emerge during the seminars were the following.

1. Be an *out-reach human link* between the client or his family and all of the many agencies, institutions and specialists he may have to see and work with in obtaining all of the services he needs. This included the notion of several sub-roles:

   a) the *out-reach* role - to reach out to people by phone or by visit to detect problems or to follow up.

   b) the *broker* or *expediter* role - to help people get to and make use of the services available.

   c) the *advocate* role - to plead for services for clients not eligible

for services by the agencies' usual practices, policies or regulation. This involves fighting the system in various ways.

d) the *intermediary* or *interpreter* role - to help mental health agencies and clients understand each others' needs, procedures, values, etc.

For several of these roles, especially when working with groups such as black ghetto residents, Appalachian poverty dwellers, or Mexican-Americans, there was a plea that the worker be "one of them" in order to be trusted fully by the people who need the services. The cultures of these groups are so different and distant from the traditional that professionals would hardly be trusted by the clients even if they tried to play the roles.

2. Be a *teacher* or *trainer* to help clients learn new or more effective patterns of behavior. Sometimes this involves teaching, sometimes coaching, sometimes providing an experience by which the client might learn.

3. Be a *group worker*, sometimes to give information or orientation, sometimes to explore problems and help clients to new insights, attitudes and behavior.

4. Provide a *role model* whereby clients will learn better ways of reacting, more satisfying patterns of behavior, and more productive and positive emotional patterns for living.

5. Be a *behavior modifier* by various means, from coaching to counseling and doing casework or psychotherapy. Behavior modification is included.

6. Be an *educator* to provide knowledge about mental illness, mental retardation and mental health to target groups and to the general public.

7. Be a *consultant* to help agencies solve problems of individuals or problem situations within their concern.

8. Be a *mobilizer* for the development of new programs and resources for the mentally disabled and for promotion of mental health of people. This

involves planning, organizing, promoting, etc., and may also involve being an advocate for new laws, rules, and regulations which would benefit clients.

9. Be a *program analyzer* to record, compile and analyze data to evaluate results and plan new strategies and programs of intervention.

There was considerable discussion of the possibility of skillfully combining some of these roles between levels of personnel so that the total effect is more than simply additive. For example, an outreach worker visiting in the home to help all family members to better understand and react with the patient (consult and teach) might be able to enhance the patient's rehabilitation far beyond what would occur if the worker functioned simply as an assistant to a professional worker (behavior changer) in the hospital. As another example, many dentists have discovered that with creative programming, a dentist and a dental hygienist can provide good dental care for three times as many patients as either could see alone.

SEMINAR 3 - NEEDS OF AGENCIES AND INSTITUTIONS

While Seminars 1 and 2 dealt with client needs and clinical activities required to meet them, Seminar 3 turned its attention to the needs and tasks that derive from the agencies and institutions themselves. We know that all mental health workers in agencies spend a considerable amount of effort in administration, record-keeping, public relations, and other efforts that are not clinical. The training of professionals seldom prepares them for these activities which may take up the greatest portion of the work day.

Essentially the agency-related activities identified by the seminar participants centered around these areas:

Personnel

Developing job descriptions
Recruiting and employing staff
Orientation and in-service training

Managing personnel actions
Supervising

Fiscal Operations

Budget preparation and administration
Purchasing
Pleading for and negotiating funds

Management

Program planning and coordination
Developing policies, rules, regulations
Conducting staff meetings
Assessing demands and needs
Keeping records and statistics
Program evaluation

Public Relations

Doing media work and informing public regarding programs
Accounting to commissioners, legislators, etc., for program
Developing legislation, regulations
Developing relations with other agencies and boards

CONSTRAINTS

Seminar 3 also considered the many constraints that are obstacles to new job formulation--legal, professional, and institutional:

Legal

In the area of legal constraints on the ways in which jobs are formulated, the participants recognized that medical practice laws, nurse registration laws, etc., spell out certain activities or responsibilities that are reserved to certain professions (i.e., prescribing medication, signing death certificates).

Sometimes the law spells out the administrative structure of a program or the qualifications of certain persons (i.e., "the director must be a certified psychiatrist"), though these limitations are rare.

More serious is the limitation of the meaning of legal liability. Many times rules or practices are set up to cover possible legal liability that someone

imagines to exist. The liability is more often imagined rather than existing in fact. Nevertheless, this is often the reason given for locking all patients up, fingerprinting patients, or for procedures such as full staff meetings to establish diagnoses or to decide when patients may go home. It is also the reason why everyone on a ward tells a patient he must "ask his doctor" whether he may go outdoors. The result is that decision-making authority is taken away from most staff and diffused among a few persons at the top level in the organization. This has the effect of "turning off" many middle-level staff persons, causing them to lose enthusiasm for the job or to seek other employment.

There is a tendency in institutions and agencies to function on the "doctrine of the possible," and "the law" is often quoted as the justification for this policy. Under the "doctrine of the possible" restrictive regulations are applied to all clients and staff because it is possible that one may do something that will make the institution liable. Instead, we should operate on the "doctrine of the probable" by giving clients and staff freedom and responsibility to make decisions unless there is reason to believe that they cannot manage it.

Institutional

A much more considerable constraint is posed by problems of personnel administration. State Merit Systems (or local systems) have certain policies and procedures that must be followed. In a few cases the Merit System is unduly rigid, but in most cases the Merit System is run to serve the agencies. Merit System staff should be involved early in the process of developing new job descriptions and specifications so that they can better understand the expectations of the agencies regarding the workers. Too often there is inadequate contact between the agencies and the Merit System, and serious

misunderstandings develop, particularly the complaint that "the Merit System won't let us" when, in fact, no one has ever explored the issue.

In general the Merit Systems write job descriptions, specifications, set salaries, etc., on the guidelines and recommendations of the agency staffs. A common problem is that agency persons insist on high qualifications for various reasons: to obtain higher salaries, to block political applicants, or to professionalize the program. Then they find their own standards frustrating when they can't recruit enough professionals and want to hire someone with lesser qualifications.

A frequent problem in the Merit Systems is the notion that a person must "supervise" other people or have a higher educational degree in order to have a higher pay level. Many Merit Systems make it difficult to recognize experience and competence. We should promote the notion of classifying the person as well as the job, but this offers problems since the job to be done must be kept as the primary focus.

Very often the agency administrator or supervisor is responsible for more rigid requirements than the Merit System while at the same time he fails to use such administrative aids as the probationary period for real probationary employee development. If better tools for evaluation of performance can be developed, we can avoid rigid insistence on educational requirements and base continued employment and promotions on performance.

Professional standards have been more closely tied to academic degrees rather than to performance. This is another reason why we need performance standards for evaluation.

There will have to be some rethinking of Merit System procedures to accommodate today's trend to "control by the client" and the need to employ persons for what they are (i.e., young, indigenous, etc.) rather than for

their education or experience. Yet we still must relate "what they are" to the job to be done.

Professional

There are several problems in professional constraints. Established professions define an area of their purview and then try to prevent persons from other professions or persons from their own profession who haven't undergone the "rites of passage" from carrying out these activities. There will be some open opposition from established professions that feel that any changes constitute a lowering of standards. The newer professions are likely to be the most sensitive to new levels and kinds of workers. Generally, however, the professions will agree in principle to the establishment of a new worker only to have opposition surface later over some individual critical incident in which individuals clash over a specific area of purview.

There is no quicker way to "turn off" a person than to tell him what he is doing is "not your area," yet the professions tend to have hierarchies and status systems that can block the assumption of duties by new kinds of workers. The current popular challenge to "the Establishment" will help with this problem.

A rather serious snobbery exists in almost all professions that see their "specialty" as most important and fail to acknowledge others. This seems to be particularly true of many psychiatrists. There must be a willingness to share the power.

Today the functions of the various professional disciplines in mental health are not as discrete as they once were. The professions frequently "blur" their roles, and there are many overlapping functions (i.e., counseling, coaching, instructing) so that it may be easier to introduce a new worker whose activities are based on these common functions.

So I said to the Chief Social Worker, "I'm the new Mental Health Generalist and will be working with patients going home."

ONE OF THE PROBLEMS IS THE JEALOUSY OF THE PROFESSIONAL OF HIS ROLE

We must keep in mind the difference between professional "competence" and professional "roles." The need is to deliver professional competence to clients without getting hung up on professional roles (i.e., seeing clients on a one-to-one basis, in the office, by appointment, etc.), and jurisdictional disputes.

It was recommended that the professions be involved in the design of training programs and in the use of new workers in agencies. This should be *involvement*, not just consultation. The workers' roles should be explained to the professions through presentations at their professional associations, meetings, and in their journals.

PART III

RECOMMENDATIONS

Seminar 4 discussed rationales for tying all of the deliberations from Seminars 1, 2, and 3 together.

In putting together the many insights that evolved during the course of the symposium, we relied on our own judgement and experiences, since the symposium did not have time to debate each point and produce a comprehensive recommendation.

The symposium recognized that mental health agencies have traditionally clustered tasks and activities according to professional specialties. Thus we have psychiatrists, psychologists, social workers, nurses, vocational counselors, occupational therapists, chaplains, etc., all practicing their specialty with clients, families, and communities in a more or less well coordinated "team" fashion. In the larger institutions the specialties are represented by departments (i.e., Department of Psychology, Department of Nursing, Department of Social Services).

It is apparent that there are some needs for middle-level workers to be simply assistants to the established professionals working under their direct supervision. This is especially true in highly technical specialties such as electroencephalography and X-ray technology which make no pretense at working with clients in a personal way. But these specialties, focused mainly on their technologies rather than on their clients, will also have to concern themselves with many of the issues discussed by the symposium. How will they keep the jobs from being menial, dead-end jobs? Can workers plan careers from these positions or only jobs? Will their training and experience at Levels I and II be acceptable either in the educational system or in the employment system for advancements without starting over each time in the educational system?

While mental health agencies have traditionally clustered jobs according to professions, there are several other rationales for grouping tasks and activities into possible job clusters. Some of these rationales spring from the needs of clients, some from the objectives of the work, some from the work itself, some from the needs of the workers, and some from the needs of the institutions or agencies (logistical considerations). While each of these rationales is used at present (and to some degree will have to continue to be used in the future), there are serious implications in the use of each. We must be very careful about which rationale is to have primacy and priority over others in planning jobs in the human services.

Major rationales for grouping acitvities into job clusters:

A. *According to target persons*

1. Individual clients, patients, families, etc.
2. Small groups of clients (i.e., 5-10 inmates of an institution)
3. Major groups or agencies (i.e., the police, the welfare department, school teachers, a neighborhood)
4. The public at large (or major subunits such as the poor, the ghetto resident, a community or city, or the aged)

The focus of these jobs is on the target individual or group and on doing all of the tasks or seeing that they are all done. Examples are the houseparent, the probation officer, the neighborhood worker.

B. *According to major program objectives*

1. Case detection and referral
2. Evaluation
3. Treatment
4. Rehabilitation and restoration
5. Care giving (24-hour care, financial care, protective services)
6. Community education and consultation

7. Promotion of mental health

8. Administration

The focus is on the objective rather than the target persons. Many functions and activities are grouped in the same job as long as they have the same objectives. Examples are the intake worker, the vocational counselor, the health educator.

C. *According to specific tasks or skills (the work to be done)*

1. Cooking

2. Housekeeping

3. Typing

4. Giving medications

5. Checking financial records

The notion of building jobs from specific tasks is most common in the assembly line of industry. Here the focus is on the task or work itself, and personal interaction with the client is minimal. Examples are the medication aide, the housekeeper, the claims investigator. The jobs tend to be repetitious and boring.

D. *According to the specialty or professions*

1. Social work

2. Psychology

3. Psychiatry

4. Nursing

These are the traditional clusters around the professions. These jobs are more sensitive to the skills, techniques, mores, and codes of the professions than to the clients or communities. Examples are social work case aides, psychiatric nursing aides, psychology assistants, recreation assistants.

E. *According to the needs and logistics of the agency or institution (the work setting)*

1. Time of day (day shift, night shift)
2. Geography (ward, building)
3. Organizational structure
4. Rules, regulations, policies, etc.

These jobs tend to be sensitive to the agency itself rather than to the needs of clients or functions. This rationale is surprisingly frequent. Examples are the night supervisor (who combines drug room clerk, switchboard operator, and nursing supervisor at night), the unit administrator, and the receptionist.

To some extent all of these rationales are used today in various parts of our mental health delivery systems. For a number of reasons all rationales will have to continue to be used for job groupings in some situations. However, there are important implications in each of these rationales. It appears that too often we choose one of the last three rationales--according to agency logistics, according to professions, or according to specific tasks--none of which is particularly responsive to client needs.

Time and time again the symposium participants spoke of the disadvantages of choosing a rationale that fragmented the services to people, particularly the sick and disabled. As an example, ward personnel are often assigned jobs according to specific tasks or activities (i.e., giving medications, feeding, or giving personal care) for all of the clients on the ward. It would be much more desirable to have a single worker assigned to a small group of clients for all activities. This would better meet their human need for continuity of a person to whom they can turn as a friend, agent, parent surrogate, or whatever.

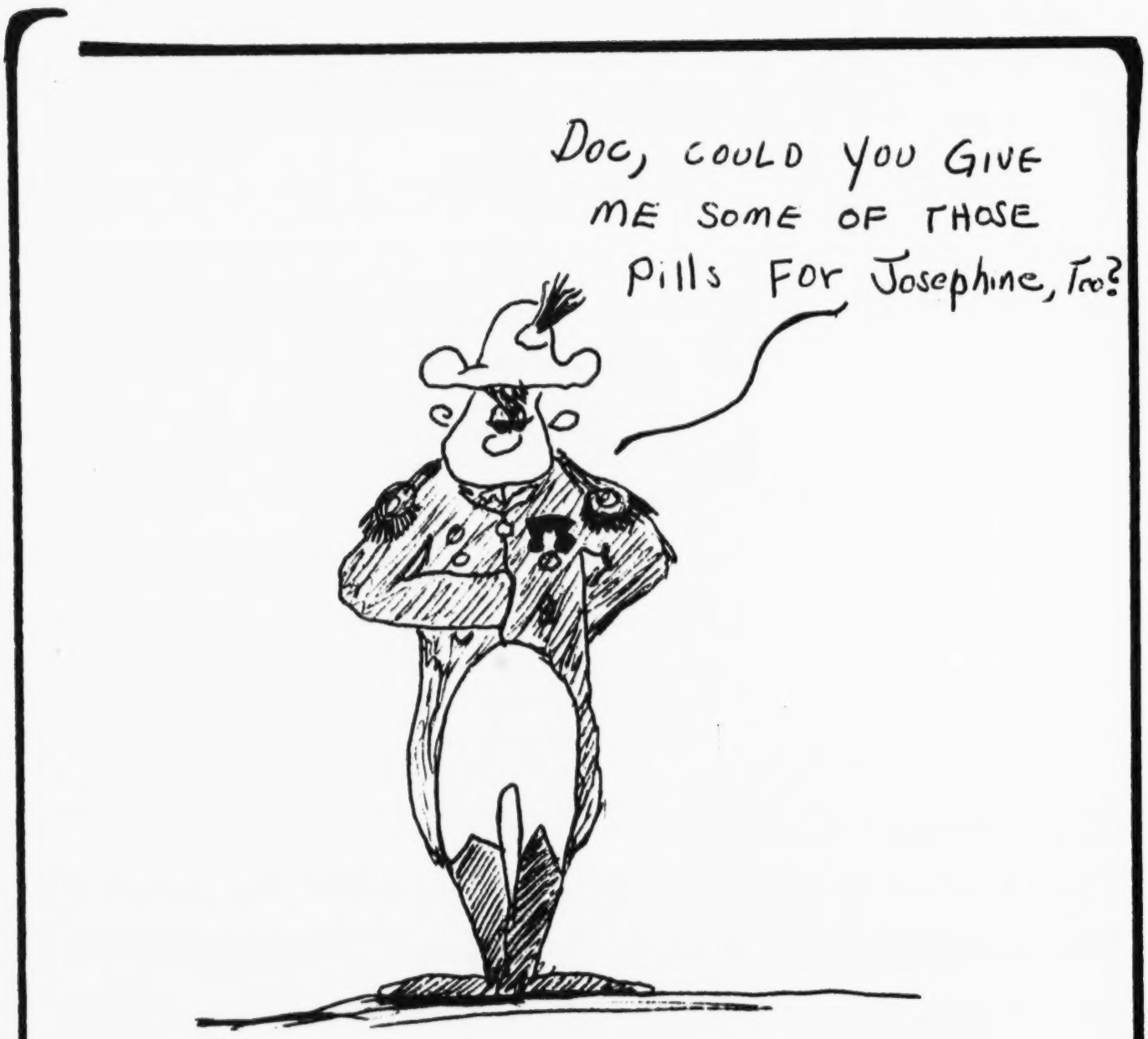
In the course of the symposium it became overwhelmingly apparent that when one starts from the viewpoint of the client or family, what is needed is *not* more professional or sub-professional specialists, but more generalists.

The fragmentation by specialties (14 or more in mental hospitals) and by agencies (i.e., in-patient unit, the clinic, the rehabilitation center) is already too much for most clients or families to contend with. Poor people, sick people, and disadvantaged people do not have the cultural, psychological, or educational resources to thread their way without guidance through the tangle of agencies, procedures, regulations, restrictions, and expectations in our complex mental health services delivery system. They do not need more finely subspecialized technicians who work within a narrow range of highly developed skills--they need a single individual they can trust, and who can help them to contact and work with the many specialists and agencies now available.

Thus we are making the recommendation that the *highest priority of rationales for clustering of tasks and activities into jobs be "target groups of persons."* These target groups may be individual clients, families, small groups of clients, or a single neighborhood or community.

This is the notion of the *generalist*. His primary focus is on meeting all of the needs of the target persons.

Models of the generalist can be found in parole and probation workers, and occasionally in public health nurses. More specific examples in the field of mental health are the mental health workers of the Florida Division of Mental Health, and the VISTA Volunteers who have worked in mental health settings (communities and institutions) in West Virginia and elsewhere. In community action programs, indigenous workers have often played the generalist role. As such, they have distinct advantages over professionals because they are more likely to be trusted by the clients and communities since they have their origins there, they know the culture, and they are more like the clients themselves--black, poor, and young.



WE MUST DEAL WITH THE WHOLE FAMILY

The differentiation between the generalist and the specialist is not here conceived to be simply on the basis of a division of labor, which is the usual criterion, but rather in a substantially altered focus of concern. We see the generalist as a person whose major concern is with a client or family or community and all of their problems, whereas the specialist has his major focus in a specialized skill or activity. The generalist helps the client or family or community to see all aspects of the problems--medical, psychological, social, economic--and to appreciate the alternatives and to follow through in whatever decision is made. The specialist is much more concerned with giving advice in his area of expertise and in applying whatever skills and procedures are appropriate to his specialty, than with *all* aspects of the client's problems. To a considerable extent the generalist is people-oriented while the specialist is procedure-or pathology-oriented.

FUNCTIONAL ROLES

In the course of the second seminar it became clear that talking of specific tasks and activities was of almost no use in formulating jobs in the human services as they are formulated in industry. Too often the same specific task or activity is performed in the human services for very different purposes. An example was given of "sweeping the floor" which might be done:

1. To clean the floor
2. To teach someone else to clean the floor
3. To provide a housekeeper role model
4. To establish rapport with a client

This is very different from the traditional industrial model of job analysis. In industry the task is the basic unit of a job and is devoid of any further meaning or purpose.

From this discussion arose the notion of "functional roles." A functional role implied a range of alternative activities and tasks carried out to a common objective. Since "objectives" is one rationale for grouping activities and one closely related to client needs, we explored further the possibilities of a secondary grouping by functional roles. This proved to be useful enough that we proceeded to base our scheme's second priority of rationales for job groupings on the concept of functional roles. The 15 functional roles that follow were the major ones explored by the symposium and in our later deliberations. Certainly they can be expanded or condensed. Thus "Behavior Changer" could be expanded into "Therapist," "Counselor," and "Coach."

Two things must be made clear about these functional roles. First, the activities in any single role are not exclusive to it. The functional roles express a "center of gravity" based essentially on the same objectives. Thus activities such as interviewing or coaching may appear under several roles, but each time would be used to a different objective.

Functional roles as identified by the symposium were these:

1. *Outreach (human link) worker*--reaches out to detect people with problems, to refer them to appropriate services and to follow them up to make sure they continue to their maximum rehabilitation. This role is only rarely played in mental health programs today.

2. *Broker*--helps people get to the existing services and helps the services relate more easily to clients.

3. *Advocate*--pleads and fights for services, policies, rules, regulations, and laws for clients

4. *Evaluator*--assesses client or community needs and problems whether medical, psychiatric, social, educational, etc. This includes formulating plans and explaining them to all concerned.

5. *Teacher-Educator*--performs a range of instructional activities from simple coaching and forming to teaching highly technical content directed to individuals or groups.

6. *Behavior Changer*--carries out a range of activities planned primarily to change behavior, ranging from coaching and counseling to casework, psychotherapy, and behavior therapy.

7. *Mobilizer*--helps to get new resources for clients or communities

8. *Consultant*--works with other professions and agencies regarding their handling of problems, needs, and programs

9. *Community Planner*--works with community boards, committees, etc., to assure that community developments enhance positive mental health and self and social actualization, or at least minimizes emotional stress and strains on people

10. *Care Giver*--provides services for persons who need on-going support of some kind (i.e., financial assistance, day care, social support, 24-hour care)

11. *Data Manager*--performs all aspects of data handling, gathering, tabulating, analyzing, synthesizing, program evaluation, and planning

12. *Administrator*--carries out activities that are primarily agency or institution oriented rather than client or community oriented (budgeting, purchasing, personnel activities, etc.)

13. *Assistant to Specialist*--This role is kept in since there is undoubtedly some need for aides and assistants to the existing professions and specialties.

Second, it is not desirable to make individual jobs out of single roles. This is again tending in the direction of specialization and fragmentation of services to clients. The rationale for grouping functional roles into any individual job or position description will depend to some degree on client needs and to some degree on agency goals and logistics. Thus an agency concerned with services to individual clients would group functional roles (Broker, Advocate, Teacher, Behavior Changer) having to do with individuals, while an agency that serves neighborhoods and communities would more likely group the roles having to do with communities (Mobilizer, Community Planner, Educator, Data Manager) into single jobs. These are related to client needs.

Other agencies-especially small agencies such as a community mental health center in a rural area--might combine nearly all functional roles into a single position, for the logistics there simply demand that each worker be

a jack-of-all-trades. However, it appears that only in a few highly specialized situations would it be desirable to make specific jobs from a single functional role (Teacher or Broker). This is tending too much to the specialist role. Nearly all jobs should be a blend of several of these functional roles, but the blending of roles and their priorities in individual jobs will have to be decided by each agency.

The charts on the two pages following illustrate some possible clustering of roles for specific settings.

After determining roles, the symposium attempted to develop some notions of levels of workers and the rationales for determining the levels of functions to correspond to them.

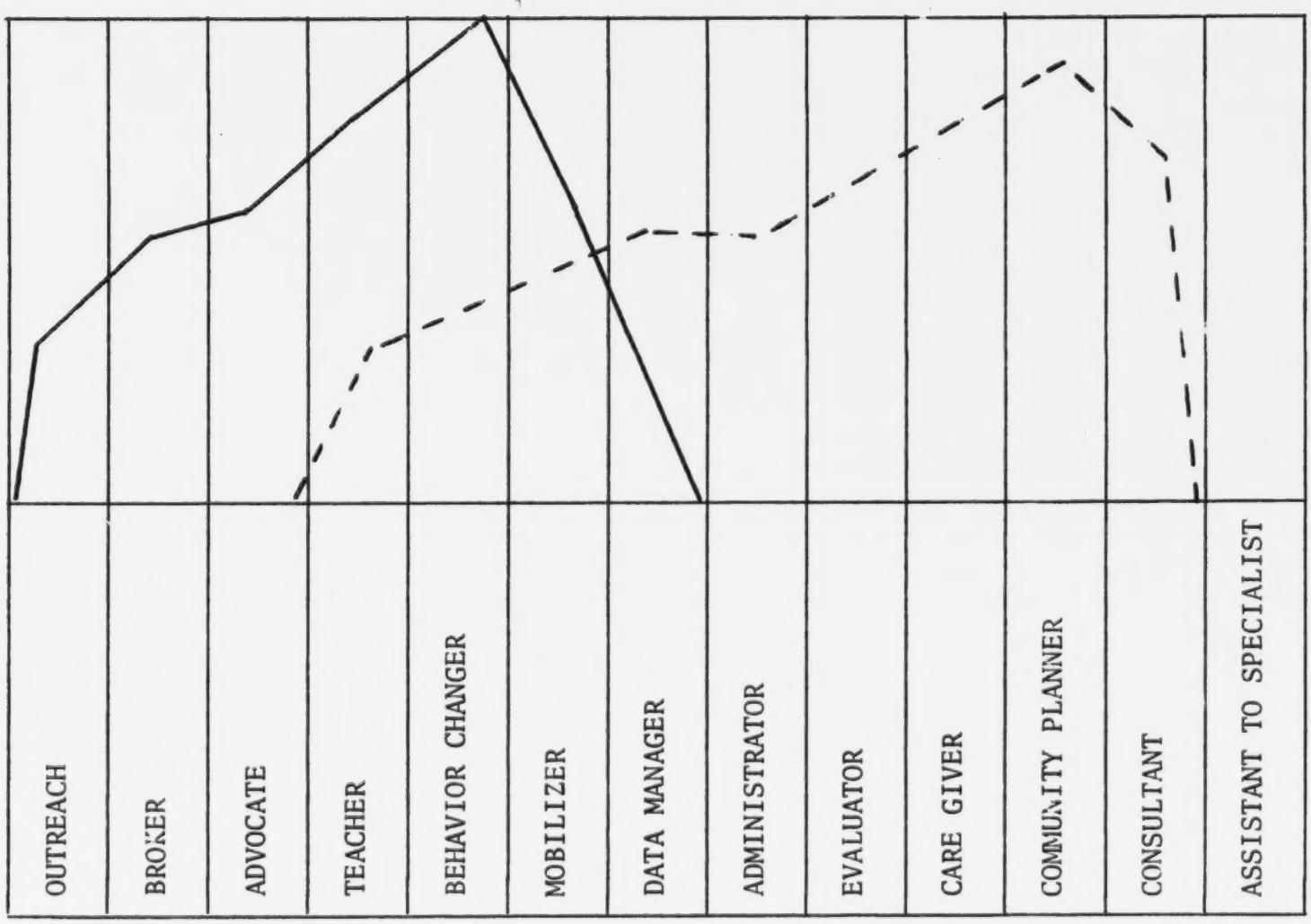
A. *Levels of workers*

In the mental health and social welfare fields today there are serious considerations being given to four rather discrete levels of workers. We easily note the extremes: the full professional on one extreme and the aide-level person who comes on the job with no special preparation other than what he receives on the job on the other extreme. In addition to these extremes, two middle levels are being recognized--one a worker with a year or two of formal training, and one a worker with the equivalent of four years of college training. We are reluctant to give these specific names and so we have simply numbered them Levels I, II, III, and IV, and noted several alternate names we have heard applied to them in various settings.

We are most reluctant to tie these levels to academic requirements, because a rigid tie to academic degrees is a major problem of our present system. Yet we need some way of relating the levels of education to level of work for people entering the employment system from the educational system. We hope, however, that these educational links will be used primarily for people entering the employment system and not as a bar to advancement for

CHART I

POSSIBLE CLUSTERING OF ROLES FOR SPECIFIC SETTINGS

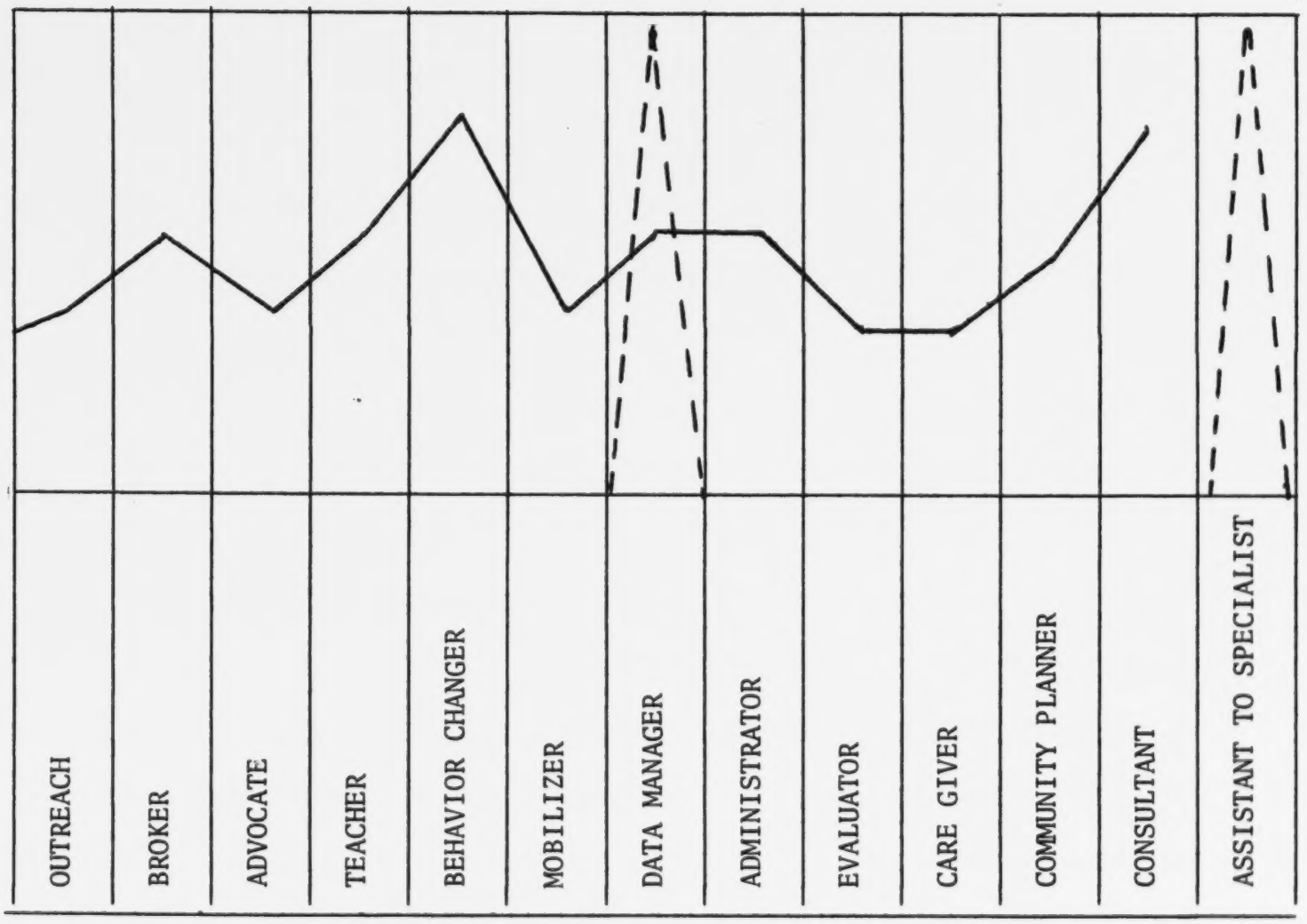


—— Job profile of the roles that might be clustered for a client-oriented mental health worker in a clinical program.

---- Job profile of the roles that might be clustered for a community services worker in a comprehensive mental health program.

CHART II

POSSIBLE CLUSTERING OF ROLES FOR SPECIFIC SETTINGS



——— Job profile of roles that might be clustered for a job in a small rural mental health agency.

----- Job profiles from a single role. This is not generally considered a desirable pattern from the viewpoint of either client needs or worker needs, but it may meet other institutional or professional needs.

workers who have demonstrated their ability to perform at a higher level, but who have not necessarily obtained the additional formal education. We expect that most persons would actually receive further education before moving to much higher levels, but we recommend that further education not be a requirement for advancement to higher levels.

The levels are:

Level I - Entry Level, Aide Level, New Careerist

This level is for a person with a few weeks to a few months of in-service or short course instruction, with no specific formal education or experience. Some agencies set a limit of eighth grade or high school equivalency.

Level II - Apprentice Level, Assistant Level, Technical Level

This level is for a person with some substantial formal course of training specific to the work he will do. This is usually a one or two-year program which gives a certificate or an Associate of Arts degree. Specific experience may be substituted.

Level III - Journeyman Level, Associate Level, Technological Level

The preparation for this level is generally a baccalaureate degree or equivalent experience.

Level IV - Master Level, Professional Level, Specialist Level

The preparation varies with the field, but is generally a master's degree or doctorate, perhaps with experience. At present there is a tendency not to accept experience in lieu of or as the equivalent of the academic degree. Professional and legal constraints in this area may need to be reexamined.

These levels are not always clear-cut; frequently they are merged into three levels and occasionally they are expanded into five or more levels. Similarly the functions noted for each level are not to be rigidly applied.

As we have discussed, many factors will influence the decision of which functions are most appropriate to which levels of workers in any particular agency.

It should be pointed out that these levels are not rigid compartments. They are guides to the kinds of functions we might expect of persons coming into the system with various stages of preparation, but they should not be used as ceilings for persons in the system. With experience and in-service education, a worker should be able to move to the next level of function without regard to formal educational requirements. A demonstration of competence should be sufficient.

Obviously, the functions assigned to any level can also be assumed by persons at any higher level.

B. *Levels of Functions*

For workers at each level we have tried to determine a level of functions that might appropriately be assigned to persons in the various roles. The variables that may be used for determining levels of functions may be either intrinsic or extrinsic to the work.

1. *Intrinsic variables*

In the symposium we first explored the variables intrinsic to the work itself to be used as guidelines for the levels of functions to assign to each level of worker. We see *complexity of the work* as a major significant variable. In general we assume that working with a single client or with a very small group of clients is simpler than working with large groups, total agencies, cities, etc. Similarly we assume that multi-problem families are more complex than single-problem families. We also assume that functions such as supervising, administering, planning and evaluating are more complex functions than interviewing, coaching, counseling, teaching, etc. This corresponds with the notions of Functional Job Analysis of Dr. Sid Fine.

Another significant variable is the *difficulty of the work*. The difficulty may be determined by the requirement of highly technical skills or activities involving extensive knowledge. It may also require extremely narrow and precise parameters of judgement and action which a worker acquires only after extensive training and experience. Pharmacotherapy, deep psychotherapy and research would be difficult by these criteria.

Still another element intrinsic to the work is the *risk dimension*. The risk element is determined by the vulnerability of the client or society if the work is poorly performed. This may be a risk to life (i.e., an acutely suicidal person) or a risk to social and emotional functioning (i.e., divorce and break-up of the family of an alcoholic). The risk dimension is not easy to determine, yet we all make judgements of this kind every day.

Perhaps the greatest problem in this scheme is to arrive at a system which assures that client problems of great complexity, difficulty or risk are brought to the attention of personnel who are qualified either to advise on the management of the case or to manage it themselves. This is a problem today with the welter of divergent professions and agencies as well as with new professional workers and trainees. The best preventive procedure is to have a congenial and supportive kind of supervision that is readily accessible so that all workers feel comfortable in bringing problems about which they have concern to the appropriate person.

It is likely that today more persons are being placed in jeopardy because of lack of time or staff to meet all needs of the patient, than because of a well-intentioned worker who might make an error. For example, patients are sometimes subjected to prolonged institutionalization because no one is availalbe to prepare and carry out release plans. These considerations should be researched, but if the goal is to better serve all of society, we must balance off the risks on the basis of probabilities--not possibilities.

THE PROFESSIONAL HAS SOME TASKS THAT REFLECT SPECIFIC COMPETENCE-TECHNICAL SKILLS

2. *Extrinsic factors*

Any agency must at times make assignments on the basis of administrative and logistical variables that are extrinsic to the work itself. Extrinsic factors that will determine the levels of work to be assigned to any level of worker are related to the agency and its policies rather than to the clients or the work itself. Some of these extrinsic variables are:

a. *Degree of prescription or discretion in the position*

Some activities are structured procedurally in advance, allowing the worker little discretion or judgement. In most cases there is some degree of discretion, but also some limitation. Some of the components of discretion are:

1) Choice of technique to be used
2) Level of achievement to be reached (i.e., prognosis, standards)
3) Scope of the system (Is the worker able to do only remedial work or is he free to attempt to change the system?)
4) Length of the effort (When is the work to be completed?)
5) Scope of resources (What can it cost?)

b. *Kind and amount of supervision*

1) How available and accessible?
2) Is it merely monitoring of procedures and standards?
3) Does it attempt to develop the worker educationally and therapeutically?

Other rationales for assignments of functions to various levels of workers that are extrinsic to the work itself, but are related to logistics and agency policies and standards, are:

c. *Needs or characteristics of clients*

For example, ghetto dwellers may need an indigenous worker at Level I regardless of the problem, whereas city commissioners may require a full professional to answer a simple question that might well be answered by a clerk.

d. *Standards and expectations of the agency*

This is related to the character of the organization. Some private agencies and their clientele expect to allow only full professionals to do the work. Others are concerned with an adequate level of performance regardless of qualification of workers.

e. *Demand in relation to resources*

Many agencies regulate the number and kinds of clients they will serve and thus adhere to arbitrary levels of manpower (i.e., teaching hospitals). Others, especially those with a public service orientation, must meet all of the demands and so assign functions to whatever level of workers seem able to carry them.

In considering the levels of functions to assign workers in each role, we have considered the insights of Functional Job Analysis which examines jobs in terms of levels of increasing complexity and difficulty in three areas:

1. What the worker does with *things*
2. What he does with *data*
3. What he does with *people*

In the mental health and social welfare fields there is virtually no activity with *things*, except using typewriters and dictating machines. The major activities are with *people*--interviewing, coaching, counseling, teaching, treating. However, a surprising amount of activity is with *data*--data

gathering, record keeping, data analyzing and data synthesis. We have applied these concepts wherever possible, although they are not always entirely compatible, especially in the *people* area, which has not been well developed in Functional Job Analysis. (Functional Job Analysis grew primarily from industrial job analysis where the *things* and *data* dimensions are most important.)

One concept that should be made clear in assigning work to various levels is that any single job may be made up of functions from several levels. This is readily apparent when Level III and IV workers are expected to carry out all of the functions of Level I and II workers, as well as those of their own level, in agencies in which Level I and II workers are not used. But it is also possible for a lower level worker to carry some individual functions from a higher level. Such assignments will depend on the individual worker's ability and in-service training. A great amount of flexibility must be used in applying these notions--there should be nothing restrictive or absolute in fitting them to actual jobs. Judgement must be used in every case.

The following pages offer a scheme for thinking of appropriate kinds of work activities for each level of worker within the functional roles. Again, we want to emphasize that we are not indicating individual jobs in each "box." Any individual job will be made up of some blend of activities from several roles and perhaps of activities from more than one level.

POSSIBLE WORK ACTIVITIES FOR
VARIOUS FUNCTIONAL ROLES AND LEVELS OF WORKERS

(THESE ARE NOT INDIVIDUAL JOBS)

ROLES → / LEVELS	OUTREACH	BROKER	ADVOCATE	EVALUATOR	TEACHER	BEHAVIOR CHANGER	MOBILIZER	CONSULTANT	COMMUNITY PLANNER	CARE GIVER	DATA MANAGER	ADMINISTRATOR	ASST. TO SPECIALIST
LEVEL I Entry Aide New Careerist													
LEVEL II Apprentice Technical Assistant													
LEVEL III Journeyman Associate Technological													
LEVEL IV Master Professional Specialist													

OUTREACH (DETECTION, REFERRAL, FOLLOW-UP)

LEVEL I

Do outreach visits, calls, etc., to homes, families, neighborhoods to detect people with problems, help them to understand the problem, and to motivate them to seek help. Let people know where help is available.

Assess and decide how to best handle problem.

Do outreach to follow up clients and assure that they are progressing with their rehabilitation in the community.

Make self available - not just *be* available

Work with families at home or in offices to help implement services, interpret laws, policies, regulations

Interview and gather information

LEVEL II

Reach out to small groups (neighborhood groups) for detection of problems and understanding

Reach out to organize and follow up groups (alcoholics, expatients, offenders)

Reach out to work with prisoners, the physically disabled and others who can't come to mental health center for services

LEVEL III

Reach out to community groups and agencies (orphanages, churches) to help them appreciate and manage psychosocial problems

LEVEL IV

Reach out to major agencies, industries, etc., to help them identify, analyze and solve psychosocial problems (i.e., alcoholism, absenteeism)

BROKER

LEVEL I

Expedite getting services for clients (fill out forms, get medications, provide and arrange transportation)

Make referrals

Give support to clients and families

Gather information and give clients and agencies (mental health agencies and general social welfare agencies such as Travelers Aid, YMCA)

Coordinate services on behalf of a client or small group of clients (i.e., 8-10 mentally retarded or psychiatrically ill persons)

Listen to crisis calls, emergency calls--coach and give information

Provide feeling of concern, trust, confidence to clients and families

Help clients to solve social problems--make appointments, alert agencies to the referral, find housing, etc.

Help families and small groups know how to go about getting services

LEVEL II

Liaison between specialist and Level I

Arrange and negotiate for services for small groups of clients with local agencies (AA, Al. Anon., etc.)

Help solve ordinary daily living problems for clients - find jobs, get financial assistance, serve as fiscal agent

Assist with legal restorations

LEVEL III

Be a liaison worker with other local agencies (welfare department, vocational rehabilitation agency)

Expedite changes in local rules, regulations, etc.

Help solve clients' social problems (jobs, housing, money)

LEVEL IV Organize a community in behalf of the mentally disabled (i.e., participation in the development of a sheltered workshop to serve all disabilities including the mentally disabled)

Provide major agency liaison for services to clients (i.e., arranging for the vocational rehabilitation agency to serve alcoholics)

EVALUATOR

LEVEL I

Attend to clues, observe and report

Evaluate client problem enough to make referral or make simple adjustment

Assess attitudes of families and clients

LEVEL II

Evaluate problems of clients, families and groups

Do intake evaluation and make "routine" decisions

Do screening tests

Do emergency evaluations (jails, schools, etc.)

LEVEL III

Do evaluation of more complex client and group problems

Make social, vocational, diagnoses and plan for groups and programs

Do screening tests and some interpretation

Do evaluation of local and neighborhood problems

LEVEL IV

Do evaluation and diagnosis of difficult or complex cases

Do evaluation and diagnosis of specialized problems (medical tests, psychological testing, etc.)

Set treatment plan for difficult cases and groups

Do evaluation of community, state, or agency problems

TEACHER

LEVEL I

Coach regarding behavior

Give simple instructions (i.e., daily living skills)

Give information and advice

Provide role model for client for social living skills

LEVEL II

Educate small client groups in daily living skills, vocational attitudes, orientation programs, etc.

Show and tell new patterns of behavior

Counsel and coach with individuals or small groups

Provide role model for clients and groups

LEVEL III

Teach or instruct clients or groups of persons

Teach staff (own and other agencies) (in-service training, staff development)

Do general public information (talks, films)

Prepare teaching materials

LEVEL IV

Teach informal training and education programs

Supervise staff development

Conduct public information programs

Direct the preparation of teaching materials

BEHAVIOR CHANGER

LEVEL I

Coach clients regarding behavior

Conduct remotivation programs

Apply interpersonal skills

Conduct programs prescribed by others (i.e., behavior modification)

Interpret programs to clients and families

Dispense medications

Be empathic listener, reassure client, interpret program

Provide experience of joy (camping programs, recreation programs)

LEVEL II

Counsel--coach individuals or groups

Serve as role model for clients

Liaison between Level I and specialists in techniques (behavior modification, group work)

Lead unit activity.

Help with physical therapies and rehabilitation therapies

Set limits and deal with behavioral reactions

LEVEL III

Counsel with individuals and groups

Do case work--ordinary situations

Direct therapeutic recreation programs

Lead groups

Monitor clients' work assignments

Local community planner and organizer

Do role playing and psychodrama

Carry out behavior modification

LEVEL IV Do Psychotherapy

Prescribe and design behavior modification programs

Do case work with difficult or complex cases

Do group work with complex or problem groups

Prescribe medication and techniques

Do community planning and organizing--cities, states, etc.

MOBILIZER

LEVEL I Promote neighborhood programs and resources for clients (i.e., encourage school to make playground available)

LEVEL II Organize local programs with guidance (neighborhood groups, etc.)

Promote and assist development of new programs and resources in local area (i.e., AA groups, evening hours for after care services)

Arrange for local agencies to serve the retarded, disturbed children, ex-hospital clients, etc.

LEVEL III Organize local community for development of programs and resources

Establish and promote social rehabilitation programs, ex-patient clubs, etc.

Promote agency program (public information and support)

Conduct workshops on behalf of programs and services

Expedite changes in local rules and regulations

Work with industry to create jobs for mentally ill and retarded

LEVEL IV Organize community--city or state

Organize and promote major programs and resources in the city, state, county, etc. (publicity, fund campaigns, develop support)

Promote changes in laws, rules and regulations (state, city, etc.)

CONSULTANT

LEVEL I Work with neighborhood workers and local care takers (clergymen, public health nurses, welfare workers, etc.) regarding problems of clients

LEVEL II Work with local agencies and workers (neighborhood centers, health clinics, etc.) regarding client and agency problems

LEVEL III Work with major community agencies (welfare departments, courts, health departments, industry, medical society, hospital authorities, etc.) regarding problem clients and situations

Conduct agency workshops, seminars, etc., regarding mental health problems

LEVEL IV Work with major state, city and voluntary agencies and units regarding problems of the agencies' clients, staff or operations

COMMUNITY PLANNER

LEVEL I

Be a neighborhood worker

Observe and report needs of neighborhood

Participate in planning

Organize in conjunction with others in neighborhood

LEVEL II

Organize small programs (i.e., recreation program for retarded, halfway house)

Serve as liaison between mental health agencies and other agencies

Organize neighborhood

Work with local workers (police, public health nurses, clergymen) to include mental health information in local plans

LEVEL III

Participate in local planning - serves on boards and committees of recreation, aging, rehabilitation programs

Consult with local agencies and programs (courts, schools, etc.)

Organize local communities - mental health assoc. executive

Help community understand mental health needs

LEVEL IV

Participate in planning major state, city, county programs to include mental health insights in planning

Consult with other major agencies and staff

Organize major communities

Serve on Boards of Urban Renewal agencies, model cities programs, juvenile delinquency boards, etc.

CARE GIVER

LEVEL I Be a homemaker

Be a parent surrogate

Be a care giver (feeding, clothing, support, recreation, ect.) for clients or small groups (mentally retarded, etc.) 24 hour or day care

Help get money, housing, etc.

Give social and psychological support (approval, coaching, etc.) to clients

LEVEL II Be a parent surrogate for groups (cottage, ward)

Help clients with money matters, housing, physical care, etc. (Determine eligibility, serve on fiscal committee, etc.)

Give social and emotional support to more complex problems

LEVEL III Provide program leadership to care for larger groups and programs (i.e., nursing homes, day care programs, terminal sheltered workshops)

LEVEL IV Provide specialized skills and services (i.e., medical services, supportive psychotherapy)

DATA MANAGER

LEVEL I

Interview and gather data, keep records

Listen and record personal history, family data, etc.

Give information

LEVEL II

Gather data - interview and record

Do investigations for courts, judges, agencies, etc.

Tabulate and analyze data of a rather routine sort

Write reports

LEVEL III

Gather data, analyze, synthesize

Evaluate programs

Plan programs (intermediate programs)

LEVEL IV

Do research (design studies, methodologies, etc.)

Analyze and evaluate programs

Plan programs (major communities, agencies, state level, etc.)

ADMINISTRATOR

LEVEL I Administer daily living services for a small group of clients (i.e., 8-10 mentally retarded youngsters)

Plan for meals, personal care services, getting clients to services, etc. for a small group of clients

LEVEL II Administer small units (wards, cottages, etc., cottage parent, halfway house supervisor)

Supervise Level I workers

LEVEL III Administer intermediate programs (geriatric service, sheltered workshop)

Plan and organize intermediate programs

Supervise Level I and II workers

Provide liaison with other community agencies and departments, units, etc.

LEVEL IV Administer major programs (state, city, county, personnel, budget, facilities)

Plan and organize major programs

Supervise staff, unit heads, etc.

Provide liaison with other major agencies (legislatures, mayors, governors, councils, commissions, etc.)

ASSISTANT TO SPECIALIST

LEVEL I As directed by specialist

LEVEL II As directed by specialist

LEVEL III As directed by specialist

LEVEL IV --

PART IV

IMPLICATIONS

There are serious implications for any system for the delivery of services whenever new levels of manpower are introduced. This is true if the new workers come into a system that deals only in hard goods and into positions with well-defined tasks and activities. But it is far more serious when the workers are coming into a human services system in which the basic activities and functions are as poorly defined as they are in the fields of social welfare and mental health and in which the outcomes affect people rather than products.

In the human service fields the goals tend to be poorly defined and tend to be stated in terms of professional inputs (i.e., to increase the number of MSW's) rather than in outcome terms of expected changes in clients. As a result, our "standards" tend to be defined in terms of professional qualifications rather than in terms of client conditions, and the agency services are often organized around professional departments (i.e., Department of Social Services, Department of Psychology). All of this gives human service agencies a strong bias toward using new levels of manpower only as "aides" or "assistants" to the established professions and departments--persons who will work under their "direct, close supervision," doing many of the same things that the professionals regularly do. Many agencies are taking exactly this approach. There are many implications in this approach (i.e., what career ladders can be established? What training experiences are needed? What patterns of supervision are desirable?) However, we are suggesting a much more sweeping change than this when we suggest that new levels of workers be generalists rather than assistants to the established professions.

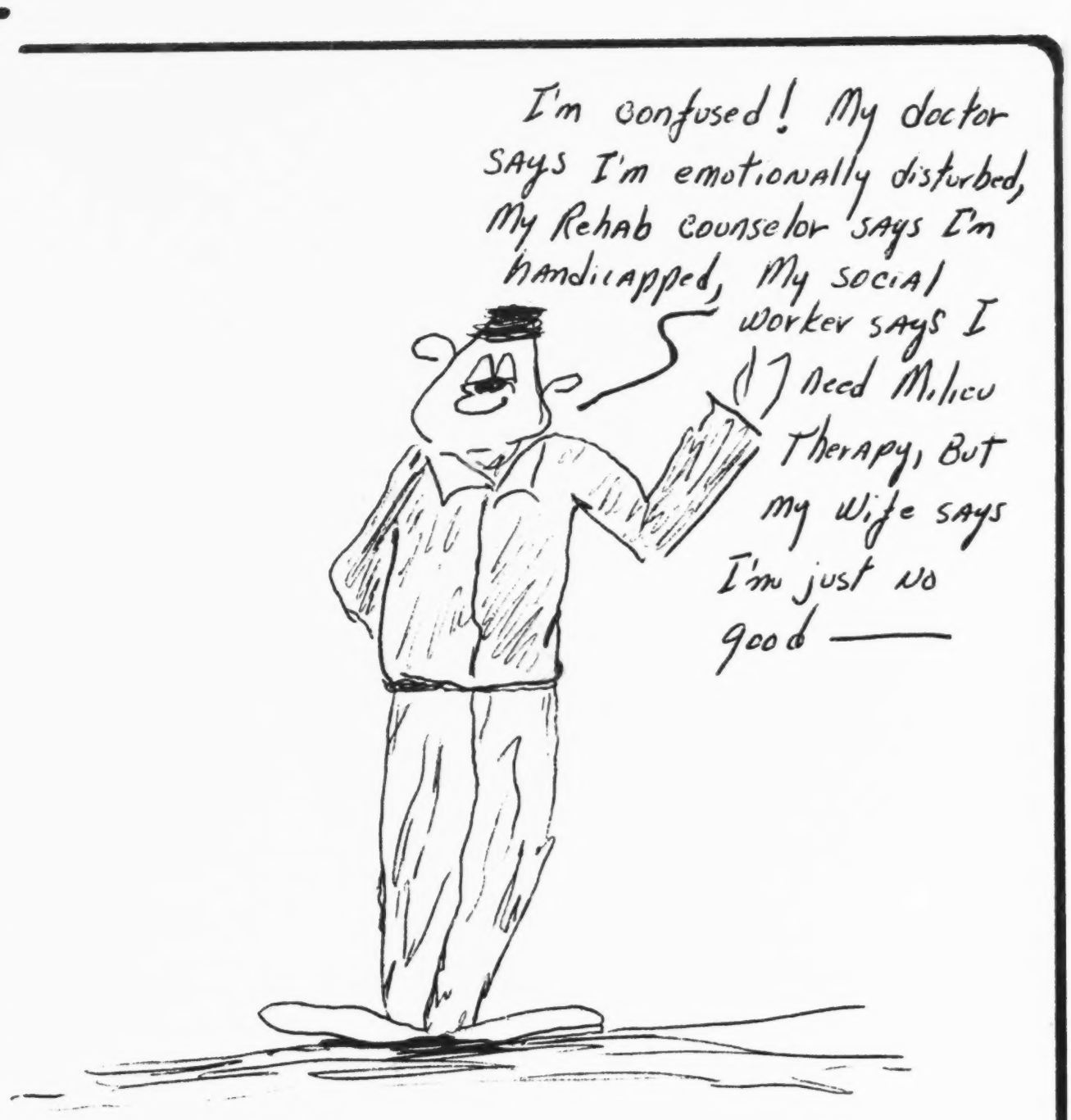
What are some of the implications of this generalist notion?

CLIENTS, FAMILIES, COMMUNITIES

For clients, families and communities, the generalist would seem to meet their real need for a single person to whom they can relate for helping them with all aspects of their problems. The generalist would not personally meet all of these needs, but would be their link to the system of professional services. The professional system, with few exceptions, does not attempt to do this. This need for a human link is universal, but it is particularly keen among the poor, the sick, the disabled, and the disadvantaged. These, of course, are the very same groups that are the greatest users of social welfare and mental health services.

The generalist at Level I can function in a major way in the Outreach function. In our system of services there has been little outreach. It is very much contrary to the "ideal" role model of the professions who see "well-motivated" clients, in their offices, during working hours only, for a fee. Yet many disabled persons such as alcoholics, oldsters, and the mentally retarded need an outreach worker to find them and to help them keep in touch with and use the system of services.

The generalist can also play the Advocate role in a way that no specialist can. If this role is really assigned to and expected of the worker, he can be of real help to clients, families, or communities by pleading and fighting for services when present rules, regulations, policies or practices would exclude them. Many times these blocks to services result from out-dated or thoughtlessly drawn rules or policies. For the good of everyone, they need to be challenged and reviewed. The traditional professionals, however, have often been the persons who set these blocks and they tend to defend them as strongly as they defend their professional standards.


I'm confused! My doctor says I'm emotionally disturbed, My Rehab counselor says I'm handicapped, My social worker says I (I) need Milieu Therapy, But my wife says I'm just no good ——

WHO'S RESPONSIBLE FOR THE CLIENT?

These workers may also work in primary prevention efforts--education, community planning, discussion with agencies regarding problems, work with officials, as well as in direct clinical work. They might be able to put mental health and social welfare in more graphic and meaningful language than the professionals presently do with their jargon abstractions. The new workers should also be able to work in many kinds of agencies besides those designated as mental health (i.e., corrections, courts, schools).

WORKERS

Several needs of new levels of workers were identified:

1. A title
2. Meaning and dignity
3. Group identity and a mechanism for communication
4. Security, recognition, response
5. Fulfillment of their "thing"
6. Some specific but generally applicable skills in interpersonal processes
7. Responsibility for a definite area of work
8. Decision-making authority
9. Training that is relevant and appropriate to their jobs
10. Variety and new experiences
11. Salaries and promotional opportunities

What will be the roles of new workers in agencies? For the most part they should not be assistants or substitutes for the existing professionals. They should not pick up or be assigned scraps of work that other professionals choose not to do or do not have time to do. They should receive support and consultation from the existing professions, but *not supervision* in the traditional sense of checking up on performance. They should receive the kind of support and assistance that will advance their personal and professional development.

Basically they should be viewed as:

1. Assigned to clients--not to services or functions
2. Advocates, Mediators, and Brokers for patients, families or communities
3. Decision-makers about patients in other than just custodial areas
4. Agents to focus on restoring human beings to society

No one likes to work in a narrowly defined activity with close supervision and no independence of judgment or action. The generalist notion offers the worker greater scope of activity, greater responsibility, and greater opportunity for exercise of decision-making, judgment, and action, although under the general direction of a full professional at some point in the system. These are all factors that lead to greater job satisfaction.

Since the generalist will be assigned to clients and families for their total rehabilitation rather than to specific services, he is likely to be continuously busy rather than having "nothing to do" or "time to kill" when his specialized tasks are completed (i.e., medications given, tests completed, etc.). This should give a higher level of commitment and involvement.

The generalist will also have greater latitude of job mobility between agencies and in different parts of the same agency. This is an advantage if the worker should move his residence to another community or if he should otherwise desire a job change.

On the other hand the generalist will not have the support and prestige of any of the established professions should he need them. In some cases there will most likely be hostility to new kinds of workers. The generalist should be prepared for this.

There was much discussion of titles for these workers. Some titles that are being used are "Mental Health Program Worker," "Mental Health Associate," "Mental Health Technician," and "Mental Health Assistant." There is need

IT'S NOT THE JOB TITLE--IT'S
THE SKILL THAT'S IMPORTANT

for an acceptable generic title that can be applied to them. However, it must be clear that these workers, regardless of their generic title, may be employed in a host of different job titles. The specific job titles will be determined by the particular blend of roles put together for each job. There will be need for specific position descriptions to describe the details of any single worker's job in contrast to the more broadly written job description for the entire class of workers.

AGENCIES

The implications of new levels of workers are greatest for the agencies themselves. This is even more true when the new worker is a generalist. The specialist aide or assistant at least fits into most of the established system, but the generalist requires some rethinking and redesign of the agency's system of organization and operation. Rethinking and redesign are things that every agency should do regularly, but they are time-consuming and painful processes, and very few agencies ever really do very much of them. This is especially true of human service agencies that are generally understaffed and not under the competitive pressures of industry and business.

Perhaps the most fundamental look that is required of an agency by the introduction of a generalist is a re-examination of its basic goals in terms of the worker's roles. Is it really the goal of an agency to reach out to detect clients, to help them get to services, to provide an advocate for clients, and to do follow-up of clients? For many agencies up until now, it has appeared that a major role has been limiting the intake of clients by rigid regulations regarding eligibility for services, such as age, disability, and income limits.

Furthermore, can the agency determine what standards of outcome it wants for clients? If we can decide what standards of achievement we want the

clients to reach, we shall be able to get out of the box of determining our standards by professional inputs and move to standards based on achievement. At present we tend to measure "case work hours by an MSW" which may have little relationship to the client's outcome, especially since we probably have only a foggy notion of what we expected the client to achieve in the first place. Counting of professional man hours is especially meaningless for a generalist at Levels I, II or III.

It is suggested that the generalist be perceived in the same manner as the parole officer or vocational rehabilitation counselor - the person who keeps the continuity of service to the client while bringing in the competencies of specialists as needed. This will require a rather substantial change in large mental hospitals where the responsibilities for patients have been carried by the professions with various kinds of "aides" used only to fill in and help out.

Using an analogy from weaving, it is as if we relaced the loom using the generalist mental health workers as the warp fibers (which are used for strength and continuity) and the traditional professionals as woof fibers (used for color and texture). Both are needed, but the total effort might be more effective than the present pattern of using the traditional professionals for continuity when their specialized skills and models do not really lend themselves to this role.

This kind of role would have to be strongly supported by administration and would very likely be much simpler in small organizations such as community mental health centers where the pyramidal effect of authoritarian bureaucracy is much less marked. This would also be much easier to fit to the "social" and "educational" models of mental health care than to the traditional "medical" model.

Can the agency give up some of the heirarchical models of operation that would make a generalist inappropriate? Many mental health agencies have moved from the traditional "medical" model to "learning theory" models or "social competence" models, but in many hospitals, institutions and clinics, the medical model remains. There is little opportunity for the exercise of a generalist's judgement and responsibility if one must always "ask the doctor." It was stressed that a position with meaning must have decision-making authority. These workers cannot succeed if they are required to work "only under the close supervision of" someone else. Power to make decisions and to act on them must be understood throughout the organization. This does not mean that the knowledge and competence of physicians and psychiatrists are to be ignored--far from it! But it does mean that the traditional heirarchical and authoritarian notion that the physician is in command of every decision must be modified in the sense of extending his *authoritative medical knowledge and competence* into the clients' overall restoration without insisting on his *authoritarian control*. The worker should not be required to ask the doctor regarding all decisions (i.e., may the patient go outside?) though obviously he will seek the doctor's decision on medical matters.

There are several other problems tied to this kind of decision-making power--most notably sex and race. There is serious reluctance to give power to women or blacks in our culture. We must work to overcome these problems.

The agency must be willing to establish a new career line--quite possibly a new department--for the generalist. This will be difficult for agencies that are strongly organized by professional specialty departments. It will be easier in smaller and newer programs, especially those that have different organizing foci such as geographic units, catchment areas, etc. This also involves deciding whether the career line will go all the way to the top, Level IV, so that the generalist might expect someday to become a

IF THERE IS TO BE A CAREER LADDER,
WHAT IS THE TASK STRUCTURING?

top program director without having to transfer into one of the traditional professions. At the same time there should be provision for the generalist to transfer into one of the specialty career lines without having to go back to school and start over. (The same should probably be true for the specialist who wants to become a generalist.)

Each agency will have to decide from several alternative organizational patterns the one that is most useful for itself. Some agencies will want to abolish all professional titles so that there is only one title (i.e., Mental Health Program Worker) for all staff persons, with 50 or 60 different grade levels into which all staff will fit. Others may want to establish a new parallel series for the newer workers while retaining the existing professional departments. In any case there will have to be relationships established between the generalist workers and the specialty workers. This will not be much of a problem for some professional departments that have traditionally had a narrow range of functional responsibilities for clients (i.e., psychology and occupational therapy), but it will be a problem for other departments such as nursing (in institutions) and social service (in clinic settings). There will be special problems in the relationships of the generalists to psychiatrists because of the legal and professional dependence of the treatment process on psychiatry. This may require a more direct access of the generalist to the psychiatrist than has sometimes been true with traditional patterns of organization where the aide's access to the psychiatrist has been through the nursing department. However, in the traditional pattern the aide has been conceived to be an aide to nursing service rather than the client's agent.

Finally, the agency will have to be willing to stand the natural turmoil of change. There are always individuals who resist any change in agencies. The established professions can be expected to give the generalist notion

some serious scrutiny. Many will see this as being even more threatening to quality services than the basic notion of using new levels of manpower within the profession.

THE PROFESSIONS

The implication of this whole notion of new levels of manpower and the notion of a generalist is initially threatening to the established professions. In the past, most professional associations opposed the development of aides or assistants, but have changed their policy positions in the past few years and are now encouraging and assisting in the development and use of new levels of manpower. This is encouraging, but some of the older members of the professions are not yet convinced, and can be expected to have some reservations about the "quality" of the work of aides and assistants for some time to come.

In addition, there is a tendency in the professions to see the work of aides or assistants in demeaning ways--to speak of "sub-professionals" and "non-professionals," to dole out only the more tedious and boresome parts of their activities to these workers, and to maintain direct and close supervision in the usual pattern of supervision.

The usual pattern of supervision is a close monitoring of performance to assure that certain prescribed standards are being met, but this is of little help to the person being supervised. What is needed is a new concept of supervision--a concept that it is the responsibility of the supervisor to help the supervisee develop to his fullest potential and to succeed in his work. Of course, this will involve teaching and counseling--not just the traditional performance monitoring--this pattern of supervision should be used whether the workers are aides to the established professions or whether they are generalists.

There is likely to be considerable question among some of the established professions about the idea of developing a new generalist, especially since the generalist will have some of the responsibilities that each profession now feels are its prerogatives. A look at these functions shows that they are actually the common skills and techniques of nearly all of the professions (interviewing, counseling, coaching, group skills, teaching, behavior shaping, etc.). A major justification for a generalist is that the role models of the professions are too closely oriented to the traditional office practice model and to the delivery of a high quality level of skills in a fairly narrow range of the client's needs. Since most professionals would prefer to stick to their models, they should be willing to work with a generalist whose model of service is more oriented to the client's total needs in a community or agency-wide setting.

Perhaps the greatest implication for the professional is to set for himself a new role model as planner, administrator, supervisor, teacher, evaluator, consultant, change agent, etc., rather than as the one-to-one practitioner. If the professional can see himself in these more complicated and responsible roles, he will not be threatened by what some feel is the "take-over" of his one-to-one responsibilities by new workers. Rather, he will see his role as the very responsible one of helping and assuring that the new workers succeed in their work. This will be difficult for many professionals who have had no training for these new roles, but it is a key consideration in the use of new levels of manpower.

Somewhat related is the notion that with the right relationship and combination of roles, the professional and the new worker can have an impact considerably greater than simply a specialist and an aide (or assistant) in traditional roles and functions. A good example is posed by the speech therapy aide who goes out to the home to work with brothers and sisters of the

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client to help them reinforce the clinic work of the therapist. This speeds the therapeutic results far greater than if the aide simply worked with the child in the clinic. This is an example of "one and one equal three" as a result of creative planning and relationships. The professions should take the lead in establishing these innovative uses and relationships with new levels and kinds of manpower.

PERSONNEL SYSTEMS

There are important implications for the personnel systems in which new levels of workers will be employed. Basically, of course, personnel and Merit Systems set up their procedures, schedules, and requirements on the recommendations and advice of the agency administrators. Thus the initiative here must come from the professionals and administrators in the agencies. However, personnel people should be involved in the planning from the very outset.

A critical issue is to decide what is different about the duties of the various levels of workers. This is a problem at present but it tends to be restricted to higher levels of workers (i.e., distinctions between a social worker just out of school and one with three additional years of experience).

There has been a tendency for personnel systems to set levels in terms of either educational degrees attained, or number of persons supervised. In the schemes we have recommended, neither of these would be particularly relevant. Rather, complexity, scope of the job and difficulty of the problems would become the critical elements. These are factors intrinsic to the work rather than characteristics intrinsic to the worker.

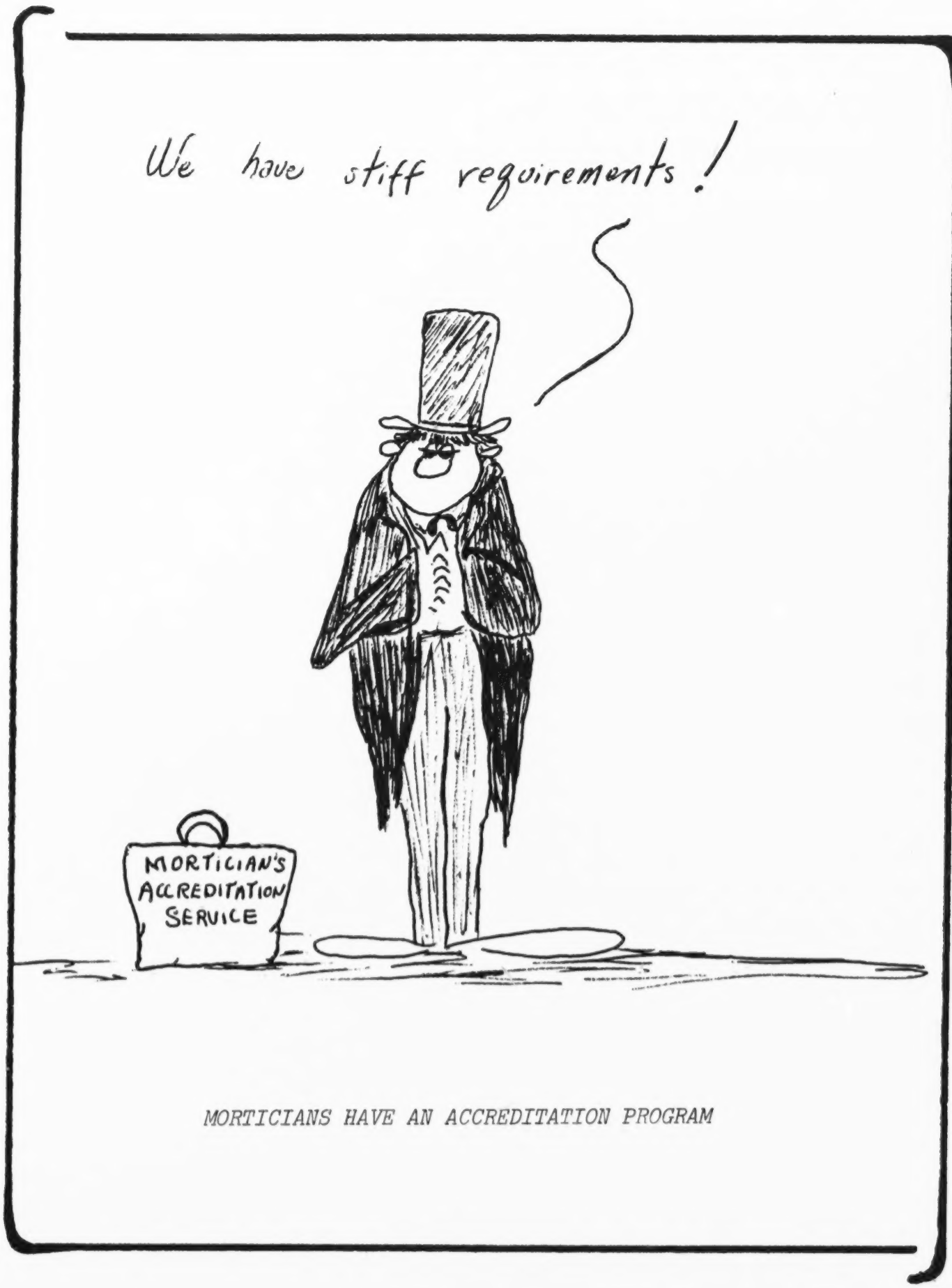
There are provisions in most personnel systems for these elements, but they need to be further elaborated and the basic functions need to be better defined - perhaps with detailed position descriptions for each job as well as the more general job description for an entire class of job.

The major problem here is to establish a new "Mental Health Worker" series that will be autonomous from other series (i.e., social worker, psychologist) and yet will have appropriate equivalency so that a mental health worker might also be employed in one of the other series when the occasion is indicated. The entry level should not consist of only routine tasks, but should have its full listing of skills and sophistication.

The generalist notion is likely to be favored by personnel departments since it allows more latitude in selection and assignment. However, a considerable amount of planning is needed to decide how a generalist series will relate in function, salary, promotional opportunities, etc., to the established professional series. We must also decide whether to extend the generalist "Mental Health Worker" series all the way through the professional levels of the organization or equivalent to the Ph.D.'s and M.D.'s, or whether to require that the worker transfer into one of the established professional specialties in order to advance to those levels. In nearly all such cases further education would be necessary, but not in a particular specialty.

The generalist notion, especially without any certification or licensure, also requires rather careful criteria for performance in order to have a basis for continuing employment, giving raises and promotions, etc.

Another problem posed by the generalist notion centers around the equivalency phrase in most job qualifications. Under the equivalency rule, persons with no particular training in the field could qualify to take the Merit System exams. Is there a body of knowledge that can be required for testing that will favor persons who have taken mental health training programs in junior colleges and four-year colleges over a person with equivalency?



MORTICIANS HAVE AN ACCREDITATION PROGRAM

There will also be a problem in selecting Level I employees from ghetto and disadvantaged areas. As previously mentioned, the client needs a person like himself he can trust, but often these persons cannot pass the usual written merit exams. Can we set up requirements based on what a person is (i.e., black, under 25, resident of the ghetto) and what he is expected to do rather than on training, experience, and written tests?

EDUCATIONAL PROGRAMS

New levels of manpower have great implications for educational programs.

At the professional school the training should prepare the student for some competence in skills such as supervision, planning, administration, teaching and evaluation in addition to the basic skills in clinical work. More important, however, is to set before the students these *role models* rather than just that of the traditional practitioner. It would be most desirable for the practicum portion of professional education to include experience in working with these new levels of workers in the new roles.

For the four-year colleges and the junior colleges there is the whole business of designing new curricula, developing field experiences, finding faculty, etc. In some colleges there is the problem of integrating the concepts of preparing a worker to practice while at the same time keeping a liberal arts orientation. Also important at these educational levels is planning with agencies to assure that the training is relevant to what will be expected of the workers in the agencies, and that jobs will be available for the graduates. Other planning will be needed with agencies for practicum opportunities and perhaps for part-time faculty.

At the New Careers or Entry Level, training programs may be developed by the agencies themselves or by technical schools. In any case they should be closely coordinated with the agencies to assure that the work is relevant.

In most settings a substantial portion of the training takes place in the agency setting so that classroom and practicum work are immediately and closely related.

The agencies themselves must pay closer attention to staff development than has often been the case. Even the full professionals will need help in agency-based training programs or in university-based workshops, for their new roles. Graduates fresh from colleges will have certain basic knowledge and skills, but they will need close supervision and in-service training in the specific operations, problems, and techniques and philosophy of the particular agency in which they go to work.

The kinds of skills we see these workers having upon graduation from two or four-year colleges are these:

1. Basic interviewing and information gathering
2. Counseling
3. Simple teaching
4. Group skills
5. Behavior modification
6. Report writing and analysis
7. Interpersonal skills (Truax triad: genuineness, accurate empathy, non-possessive warmth)

The basic knowledge will be in areas such as:

1. Kinds of disability and their meaning
2. Concepts of treatment, rehabilitation, prevention, promotion of social well-being, etc.
3. Knowledge of the social welfare field and mental health field and society's mechanisms for dealing with these problems
4. The professions, agencies, and procedures that are involved in the field.
5. Basic psychology, sociology, etc., regarding personal and social growth, development, and normal and abnormal interactions

MOST TRAINING IS REALLY INAPPROPRIATE FOR USE IN THE SYSTEM

Beyond these competencies, the agencies will have to prepare the workers in agency-specific procedures or skills such as giving psychological screening tests, or teaching specific skills.

FINANCIAL IMPLICATIONS

There appears to be a fear in the minds of many professional persons that administrators, budget analysts and legislators will see the use of middle levels of manpower as a cheap source of labor to replace professionals. On the other hand, there is a tendency for administrators to claim that they cannot implement any such changes without great new sums of money. Probably neither one is correct.

New levels of manpower are perhaps best seen as a way to render more effective services rather than as a way to save money. Professionals are still needed to give competent direction, planning, organizing and supervision. There also must be a firm commitment to staff development--both in-service training and continuing development. In addition to the needs for professionals, the cost for the new levels of manpower is a very substantial one. For instance, it appears that a Level II worker should receive about the same salary as a beginning nurse. Thus the costs of new workers will be comparable to the traditional ways of using manpower. It is in total impact and effectiveness of the total organization that new levels of workers will show their worth rather than in cost savings.

For the administrator, it is probably not necessary to have new money. Much of the cost of using new levels of manpower can be found within existing budgets by shifting priorities and reallocations if the administrator is really committed to finding a way to do it. Vacancies occur quite regularly in most organizations; some of these positions can then be reclassified for new workers.

In addition, it may be possible to obtain funds from federal programs to help with parts of this--especially the initial training under the Scheuer Amendments of the Department of Labor, the Vocational and Technical Education Division of the Office of Education, or other agencies. Regulations for staffing of community mental health centers are being rewritten to allow for employment of new levels of manpower in addition to the traditional full professionals.

LEGAL IMPLICATIONS

At this point there seems to be little change in the legal liabilities of this pattern of new workers. The legal liabilities are likely to be greatest in situations that remain closest to the traditional medical model in which the physician is considered to be liable for the actions of all of his agents (paraprofessionals, assistants, aides, etc.). The liability with a new level of worker will be no different from that at present. However, as the program shifts its focus away from the traditional medical model to models based on social competence or behavior learning, the total liability will be less. This also allows more freedom for a broader team of workers. The generalist notion will fit better here.

The questions of certification or licensure have not yet arisen to any great extent. We would prefer not to see a movement to certification or licensure for new workers until guidelines for their uses and functions have been much better defined and tested than they have so far. There is no doubt the certification and licensure laws freeze the functions and contribute to some of the problems we face with professional jurisdictional battles today. In many cases such laws appear to have been developed more to protect the professions than to protect the public from harmful practices or practitioners. Until there is greater clarity of just how the public might be harmed

by new workers in agency settings, we might do well to steer clear of certification or licensure laws.

There may be some concern about invasion of privacy if an outreach worker were too aggressive in his pursuit of a client. This should be guarded against. Certainly most clients will welcome a person extending himself to help them. For those who resist because of paranoia or brain damage, but still need the service, it may be advisable to consider changing our commitment laws so that the person is committed to treatment (whatever is indicated) rather than committed to an institution as at present. This would give workers the authority to reach out to persons in the community as well as to work with them in the community. Other potential clients who resist outreach services, but are not dangerous or grossly disturbing, should be left alone.

THOUGHTS FOR IMPLEMENTATION

There are obviously very serious implications for ways in which these kinds of guidelines might be used in any particular agency. The notions have significant importance for so many parts of the agency that it would seem to be difficult either to implement them piecemeal or to impose them from the top.

We have explored possible approaches to implementation with several agency people and have listened to their suggestions.

It appears that a logical first step is to have a rather extensive working session for the key administrative and professional leaders of the agency to explain the developmental approach, to explore these recommendations and their implications, and to be sure that everyone understands the processes. In addition to providing an opportunity for the agency people to ask questions, it will also provide a chance for them to express their reservations about the process and to begin to think of how it might be modified for their own agency.

A succeeding work conference of the same people held a short time later might then explore the agency's total objectives and priority commitments to determine just how much of each functional role belongs in the agency's operation. This also would involve deciding in what ways present responsibilities and administrative and programmatic relationships might be changed.

Expert committees could then work on setting up new job and position descriptions, organizational patterns, tables of organization, etc. to implement the overall plan.

Another session (or sessions) would be required to orient all staff to the new plan to assure that there is full understanding. Implementation

might then be undertaken in the entire agency at a single time or in various units over a period of time.

In the actual implementation phase, constant and careful attention should be paid to critical incidents and problems that will need to be detected, examined and resolved.

This process will not be easy in any case. It will need strong support from the top leadership in the agency and a firm commitment of time to work out the adaptation of the whole process. It would be well to have representatives from personnel and budget divisions involved in every step of the process so that they will understand what is being done and can lend their support and assistance to the actual implementation.

It would also be well to have someone skilled in program evaluation to participate in the process and help design an evaluation procedure.

CONCLUSION

In the Introduction we compared the proposal set forth in this paper to a basic highway map of a country that previously had only railroad maps. We are offering a plan for the use of new kinds of middle level workers for the delivery of mental health services in a system that had previously used mainly professional level workers of a few select specialties. Each agency will have to decide whether it wants to move to such a new system of services at all. If it does, we hope this scheme will be useful. But like a highway map, it does not spell out all of the details such as driving times, speeds, or choice of vehicle. Each agency will have to decide what combinations of roles and levels it wishes to apply in its own situation to reach its individual goals.

Our proposals are not to be applied rigidly in any situation. Nothing here is to be used as a job description, since writing specific job and position descriptions is a task for each individual agency. We do hope these ideas will be useful to administrators of mental health agencies and to trainers of new levels of mental health manpower.

SO MANY WORKERS IN THE FIELD OF MENTAL ILLNESS BECOME SAVIORISTIC

APPENDIX A

NEEDS OF SELECTED TARGET GROUPS AND ACTIVITIES TO MEET NEEDS

The list which follows is an illustration of the process of the developmental approach, and a basis for the identification of roles and clusters of tasks that might be formed into jobs. Needs and activities are not always matched one-for-one in the listing. For example, under *TARGET GROUP - People in Crisis*, there are 12 needs listed and 32 activities to meet the needs.

The examples illustrated are reproduced here as they were identified by the participants in the seminars. Also, some needs and activities were considered common to many target groups and therefore are not listed under each group, although some duplication does exist. Some groups such as unwed mothers, alcoholics, prisioners, etc., were identified but are not listed here as specific target groups.

TARGET GROUP - People in Crisis

Needs	*Activities to Meet Needs*
Outreach visits	Go out and see people and families
An empathic listener whom the client can trust and who knows his culture and language	Call people on telephone, ask about problems, give advice, reassure, listen, refer, give information
Knowledge of where to go for help and how to get it	Assess and decide how and where to handle problem (in community)
Someone to smooth his path to the services needed	Make decision and act
One human being who is his agent and link to the system of services	Motivate and direct people to get help
Limited number of agencies to deal with, all of which accept the evaluation and work of others	Be a human link between people needing help and professionals, agencies, and institutions

Council and support	Help make contacts; be continuity for client
	Interpret laws, hospital policies and practices
	Counsel epileptics, alcoholics
	Refer to hospitals, clinics, and then follow up to assure that services are given
	Work with AA groups, Al Anon, etc.
	Know and refer to Travelers' Aid, YMCA, YWCA, Salvation Army, etc.
Respect, Dignity and Compassion	Provide feeling of trust and confidence
	Show concern
	Respond in a way to meet client's needs and move to help (not just a show of kindness and understanding, but know person's needs)
Immediate evaluation and action	Move to block crises
Transportation to services	Assist in making arrangements for transportation, medication, living needs, etc.
Flexible policies, practices, and laws	Defend legal rights
Support from his family and community	Stick up for person (rules, regulations)
	Provide homemaker services
	Do emergency consultations
	Assess attitudes and feelings of families
	Counsel in groups and families
	Lead patient groups
	Work with day programs (observe, counsel, talk, question)
	Show and tell new ways to handle behavior

	Set limits and deal with reactions
	Do role playing, psychodrama; help with physical therapies
	Get information, permits signed, etc.
	Answer suicide calls and crisis calls
	Relate to daily life of client and his family
	Work with prisoners

TARGET GROUP - *Clients at Admission*

Needs	*Activities to Meet Needs*
A person to help client relate to all specialists and services	Be human link to all services, coordinate services for patient
Early and appropriate evaluation (social, vocational, physical, psychological, psychiatric - not drawn-out ritualistic studies)	Attend to clues, observe
	Respond actively
	Do psychological screening
	Assist with procedures of admission Initiate sometimes
Counsel and orientation	Explain staff's needs and what will happen
Dignity and humanity	Talk with patients about what they are going to do during therapy and on release
	Be empathic listener, reassure, explain what's going on
Appropriate therapy promptly; medication, individual therapy, group therapy	Dispense medication
	Counsel, help with physical therapies, etc.
Supervision, but maximum self-responsibility consistent with safety	Make self available (not just be available)

A person he can relate to	Be genuine, warm and non-possessive with accurate empathy, understanding
Family contacts	Counsel with client and his family, explain what's happening
A treatment plan he knows and can follow	Interpret plan, follow up to see that plan is followed and understood by client
Civil rights	Defend client's rights

TARGET GROUP - *Patients in In-Patient Units*

Needs	*Activities to Meet Needs*
Dignity, humanity, compassion	Give understanding and empathy, inquire and observe patients feelings and reactions
	Provide experiences of joy
Guidance and help to better patterns of living	Conduct group counseling
	Counsel and work with patients
Medication	Prescribe medicine
	Teach and encourage patients to administer own medicine when able
Responsibility, independence	Encourage patient to do for self
Home planning, family visits	Work in groups (art, music, home-going, orientation to hospital)
Physical care	Give physical therapies
Improved appearance, grooming	Work in barber shops, beauty shops, commissaries to help patients
	Help with personal care skills such as grooming, eating, dressing
Role acceptance and experience	Use behavior modification programs
	Serve as role model (sexual, social, etc.)
Self-respect	Give support - conversation, listen to problems, discuss, play cards,

	go bowling, take walks, prepare meals with and for patients (provide interpersonal and social experience)
Full day of activities and responsibility for planning them	Lead unit of activities
	Take shopping, to shows, sports events, etc.
Recreation, Spiritual fulfillment, Social activities, Work	Direct or assist programs in recreation, social activities, occupational therapy
	Assist in rehabilitation programs (industrial therapy, supervise placements, assure that patient is trained, supervised, etc.)
	Provide camping and like experiences
	Work with adolescents in wood shop, etc., to establish therapeutic relationship
	Conduct and supervise remotivation
	Help patient establish new patterns of action and reaction
	Prepare patients for realities of work; check on job habits, adjustments, etc.
	Monitor patient work assignments
	Do psychological screening and intake interviews
	Provide opportunities for civic clubs and groups to see and work with mentally ill persons (have patients visit clubs)

TARGET GROUP - Patients Nearing Release or Ex-Patients

Needs	*Activities to Meet Needs*
Human contact (someone to contact him and keep in touch)	Make self available consistently and continuously
Outreach and support (they are frightened)	Give adjustment counseling and assistance

Help to overcome objectionable traits	Help patient unlearn dependency, passive, irresponsible role; teach sexual behavior
Ability to make decisions, exercise of initiative, responsibility	Coach in adaptive skills, help them to help themselves
Help to better patterns of emotional response	Counsel in groups - actively visit, counsel with person (at least 3 months to help over crises and to head off problems)
Meaning and purpose in life (in family, work, hobby, religion)	Provide spiritual base, help with leisure time plans (church, recreation, etc.)
Social and recreational skills (riding the bus, using the phone, shopping, etc.)	Help patients continually better their social adjustment and provide learning experiences (take downtown on bus for shopping trips)
Good grooming, dress, habits	Establish and participate in expatient clubs, social rehabilitation programs, etc., where grooming and adaptive skills can be learned
Personal, home and budget management know-how	Work with groups and in individual sessions to provide home making, budgeting skills
A job - contacts and preparation, job skills, habits and attitudes	Plan with person about job, find out where jobs are available and the qualification requirements; help person with arrangements for interview (even bus fare); train in job skills, habits and attitudes, give prevocational tests and training; persuade employers, coach on idiosyncracies and how to handle.
Patient group meetings (with families)	Work with families and employers
A living plan and arrangements	Plan with patient about living arrangements; make or provide living arrangements (i.e., nursing homes, personal care homes, halfway houses, etc.)
Preparation for facing demands of society	Prepare patients for realities (group and individual counseling re: rejection, standards, being on time, etc.)

Knowledge of medicine, how to take, importance of taking it, toxic effects, etc.	Teach drug effects, importance of following medical plan, follow-up to see that patient understands
Models of successful persons	Provide ways for some ex-patients to provide models for others, make self available as a role model
Person to reach "pop-outs" (people who terminate contacts without explanation)	Check on broken appointments, keep in touch with patient
Understanding of their culture, language, etc. - handles to function in their society	Be aware and attend to clues from people. Talk to them and ask about their plans, how things are going; relate to them in a manner that fosters trust
Family understanding and acceptance, understanding of residual disabilities and limitations	Counsel with families, explain, discuss, interpret in a language they can understand
Self-identity and self-acceptance, meaning to life	In groups and individual sessions help patients find a purpose for their existence
Group sharing of experiences, plans, etc. (i.e., what to tell employers) how to use leisure time	Group discussion sessions, planning for everyday living, etc.
Learn not to distort what is happening to them	Prepare patients for realities of everyday living, interpret things they don't understand, help to get along with others (i.e., on job, in living quarters, etc.)
Help with practical problems (food, housing, money, transportation, clothing, etc.)	Develop and work in halfway houses and social rehabilitation centers, group sessions and discussions on handling practical problems
Help with loneliness	Be available for calls and visits, reassure, involve in ex-patient clubs, help start hobbies, etc. Provide opportunity for group evening sessions
Fiscal "Committee" or guardianship (sometimes)	Assist with legal restoration procedures case
	Attend conferences of other agencies on behalf of patient
	Serve as fiscal agent

	Provide continuity for patient through all the many services

TARGET GROUP - *Disturbed Children and Families*

Needs	*Activities to Meet Needs*
To have problems identified before crises	Visit homes to observe and counsel Make decision and act Detect danger signals in well-baby clinics
Understanding of battering parents (not punishment)	Give families counsel regarding management, discipline, etc.
Guidance on emotional development in well-child clinic, etc.	Provide counsel
Information on child rearing and problems (printed and personal), and consistency in management	Help parents with behavior training, work with parents to help them understand problem, and how to manage.
Creative outreach devices to parents	Work with groups: play games, take on trips, encourage to talk about problems and experiences
Help for children with social crises (fights, separations, death, etc.)	Give advice and guidance, explain, reassure, explain illness to siblings
Education - regular and remedial	Work with teacher in school to help her understand and manage, study educational achievements, and abilities
Experiences in wholesome living	Participate in or conduct play therapy, (observe reactions, play with child, report); encourage expression of emotions and direct in new ways
Adaptive skills and behavior	Teach skills, values, attitudes; behavior modification, provide experiences in everyday living (getting along with siblings, parents, teachers, etc.)
To unlearn unacceptable behavior	Find out what child was like before--at home, school, etc., socialize (talk, play, train) be a model for child to imitate

Physical care	Help with physical needs (cleanliness, grooming, diet, dress, etc.)
To be picked up, played with, loved, mothered	Be available, be someone children "belong to," demonstrate interest in children's everyday life
Parents need help in home management	Provide babysitters and homemakers
Help parents through crises	Listen to families' concerns and respond--understanding and empathy
	Advice about how and where to get help; observe and report families and relationships; screen problems
	Screen children for clinics, see children from juvenile court--give close attention and involvement (group and individual)
	Do psychological screening, testing and scoring
"Abandoned" children need loving foster parents	Help couples with adoptions

TARGET GROUP - *Mentally Retarded and Physically Handicapped Children and Adults*

Needs	*Activities to Meet Needs*
Special help with cognitive and social education and training	Assist teachers (preparation and programs)
	Encourage language development, extend speech and hearing training to home
	Study educational ability and achievement, also social, physical, leadership, and other abilities
	Translate behavior modification program into action
	Provide limits and settings for social growth
Day services (activity and training), Sheltered Workshop opportunities	Teach educables in day programs
	Train in self-care skills (personal hygiene, dental care, general health)

	Teach social skills, carry out behavior training
	Teach to walk
	Lead unit of patients in training
	Train and assist to provide for self
	Work with sisters and brothers of handicapped
Special help to involve in activities	Conduct activity programs, provide experiences of joy
Physical care (severely retarded or physically handicapped)	Help families cope with dressing, training, behavior, feeding, discipline, controlling drooling, preventing contractions, etc.
	Assist other professional (OT's, PT's, ST's, etc.)
	Teach mobility skills and homemaking for blind
Touch, acceptance, love of a single person, special efforts to keep humanized	Be human contact (parent substitute, love, play, support, understanding)
	Supervise Foster Grandparent program
Recreation suited to ability	Conduct or assist in recreation programs
Development of their "well" parts	Teach to use abilities to full potential
Parents need help in handling anxiety, guilt, frustration, etc.	Reach out to counsel (meaning of retardation, institution, etc.), prepare families for separation, coach parents on problems
	Bring parents and children to institution to see, discuss and decide
	Visit homes to observe and counsel
	Listen to concerns and give correct information
	Conduct family or parent discussion groups
Help to get services	Counsel families on what home can do, resources, alternatives, etc.

	Help arrange for other community agencies to serve retarded and handicapped
	Change restrictive rules, regulations
	Prepare application forms for services
	Keep community resources in touch

TARGET GROUP - *Communities*

Promotion of Positive Mental Health in the Community (Schools, the Home, Church, Welfare Agencies, Health Departments, Industry)

Needs	*Activities to Meet Needs*
Awareness that mental health is more than just treating mental illness	Help schools add mental health to health, psychology, and sociology courses (teach the course if necessary)
Schools and teachers need insights and support in emotional growth and development	Conduct workshops; give talks; show films; visit schools to observe and advise; send teachers and schools printed materials on promotion of positive mental health
	Teach classes regarding sex education, alcohol, VD, mental health careers, etc.
Practices and programs to enhance motivation and social effectiveness	Counsel school children, families, agencies, conduct workshops
Civic Clubs, Women's clubs, etc., need insights and projects in mental health	Teach about mental health, emotional problems, projects to enhance functions of youth, etc.
	Consult with agencies regarding mental health in general: juvenile courts, law officers (police, sheriffs), schools, health departments, mental health planning groups, urban planning group, welfare
Understanding and commitment to mental health and human problems	Conduct workshops, in-service training sessions, etc., regarding emotional needs and development of people

Removal of physical hazards (air pollution, noise, dirt), stimulating physical environment	Work with industry to stress the human elements of work
	Work with urban renewal agencies, Model Cities, etc., to give a human dimension conducive to mental health in their plans and developments
	Serve on boards and committees related to recreation, aging, juvenile delinquency, etc.
	Participate in community planning boards and committees (aged, delinquency, etc.)

<u>TARGET GROUP</u> - *Communities*

Prevention of Mental Illness in the Community (Schools, the Home, Church, Welfare Agencies, Health Departments, Industry)

Needs	*Activities to Meet Needs*
Commitment to people--not just economics and industry (i.e., kindergartens, Head Start, recreation, anti-poverty programs)	Interpret community needs to state and area-wide agencies
Knowledgeable policy makers	Advocate change when needed
Changes in laws, regulations	Pass Interstate Compact on Mental Illness
	Change policies and practices--demonstrate; document draft changes; assess problem who, why, when; bring problem to attention of proper people
	Evaluate programs
Enlightened press and civic leadership	Work with press to set a more favorable image of mental illness
	Explain "mental health" in ordinary language and terms
	Give public information about mental illness, mental health, mental retardation

Schools need commitment to working with slow learners, troubled children, etc.	Help teachers and principals, etc., understand problems of slow learners and troubled children. Help to work with children
Help in organizing mental health and mental retardation associations	Organize or help mental health associations, associations for retarded children, halfway houses, etc.
	Serve on boards and as executive director of mental health associations
	Promote and help ex-patient clubs
Identification and modification of obvious stresses that cause anxiety, depression, etc.	Gather and analyze data regarding community problems
	Work with kids in neighborhood groups
	Knock on doors, ask questions "how is baby?" "how do you manage?"
Sense of identity with community	Know community and what is going on, encourage people to take part in community affairs, motivate to participate
Well-known emergency contact point	Mail materials, use TV, newspapers, etc., publicize names of agencies, crisis telephone number, etc.
Crisis service (telephone calls, etc.)	Move to block crisis
Out-reach follow-up on crises	Work with physicians on admissions, follow-up, etc.
	Serve as liaison to ministers, employers, welfare officials regarding returning patients
Transportation	Arrange for transportation through local women's clubs, etc.
Available and accessible services, and limited number of agencies to take responsibility	Coordinate services
Understanding and tolerance of mental illness and emotional disturbances and reduced stigma of psychiatric illness and care	Provide talks, films, etc., regarding mental illness, retardation, etc., for groups

	Work with journalists, ministers, teachers, law officers, etc., to understand problems of mental illness and retardation. Mail materials regarding mental illness
Mechanism for detection of problems	Visit prisons, jails, etc., observe, listen, advise
	Work with parole and probation workers
Knowledgeable care-taking agencies and professionals, police, health departments, welfare departments	Train agency workers to be more responsive and more understanding
	Serve as liaison between clinics and local government, agencies
	Accompany sheriff or policeman on calls about disturbed people
	Conduct police--sheriff orientation sessions
	Know and approach decision makers to change attitudes and practices
Appropriate and relevant mental health services in community	Back-up and counsel in dealing with problems
	Change laws, regulations, policies, Blue Cross coverage, commitment laws, liability, etc.
	Work with public health nurses in aftercare, well-baby clinics, etc.
	Help plan and operate preventive programs
Understanding and help with the alcoholic, the accident prone, absenteeism, mentally ill, and human relations (industry)	Work with industry regarding these problems
Persons (volunteers) knowledgeable about how to make contacts with people	Organize people in community to visit with the aged
	Make investigations for judges, juvenile courts, etc.
	Work with police departments and sheriff's offices
	Work with colleges re: suicide rate
	Work with county extension agents

	Do psychometric screening exams for schools, Voc. Rehab., children's agencies
	Participate in in-service training programs
The aged: to feel wanted, to stay engaged and humanized, to stay physically active, community settings and services, physical and nursing care (sometimes) Meals on wheels--homemaker services	Work with and in nursing homes, old age homes, etc.
	Help nursing homes, etc., staffs to understand and manage emotional needs and problems including recreation and crafts activities

APPENDIX B

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